



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cálíocht Sláinte

**Social Services
Inspectorate**

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE Midlands Area

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1. Findings

1. Introduction

The Health Information and Quality Authority Social Services Inspectorate (HIQA SSI) carried out an unannounced inspection of a children's residential centre in the Health Service Executive Dublin Mid Leinster (HSE DML). Kieran O'Connor (lead inspector) and Orla Murphy (co-inspector) conducted the inspection under *Section 69 (2) of the Child Care Act 1991* from the 30th to the 31st of March 2008.

The centre was located in a two storey detached house located in a residential area on the outskirts of a large town. It provided emergency, short, medium and long term care for children and young people in the care of the HSE. At the time of inspection there were two girls, aged fourteen and sixteen years, living in the centre. One of the young people had an access arrangement with another residential centre where most of her siblings resided. A third young person was placed in a Special Care Unit but remained on the centre register pending a decision on his long term care.

The centre had been subject to a previous inspection by the Social Service Inspectorate in February 2006 and most recommendations had been met. A key recommendation to develop and implement a comprehensive aftercare policy had not been met.

Inspectors found a high degree of staff commitment and care again for young people during this inspection. While the young people felt respected and cared for the management of their behaviour was problematic. Some young people engaged in behaviours that placed them at risk of serious harm. Inspectors held the view that the manager and team had to improve their capacity to keep young people safe. In this report recommendations are made in relation to management of high risk behaviour, leaving the unit without permission, formal staff supervision, education, and aspects of accommodation, including fire safety.

1.1 Methodology

Inspectors judgements are based on evidence of findings verified from several sources including: direct observation of interactions between staff and young people, a review of records, an inspection of accommodation, interviews with two young people, the centre manager, four child care workers, and the regional residential manager. Telephone interviews were conducted with a parent of one of the young people, the monitoring officer, a social work team leader, and two supervising social workers.

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

- The unit's statement of purpose and function
- The unit's policies and procedures
- The young people's care plans
- Questionnaires completed by parents, young people, care staff, social workers
- The monitoring officer's reports
- The young people's care files
- Administrative records
- Details of physical restraints
- Details of unauthorised absences

1.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, staff and all other professionals involved in this inspection.

1.3 Management structure

The centre was one of four residential centres for children which served the local health areas of Laois/Offaly and Longford/ Westmeath. The centre manager reported to the HSE local residential manager for children who in turn reported to the general manager.

1.4 Data on young people

At the time of inspection, the following young people were residing in the centre:

<i>Young Person</i>	<i>Age</i>	<i>Legal Status</i>	<i>Length of Placement</i>	<i>No. of previous placements</i>
#1 girl	16	Voluntary care	8 months	1 foster care /3 residential care
#2 girl	14	Care order	6 weeks	3 residential placements

Practices that met the required standard

Primary care

The young people in the centre received a good standard of primary care and their health needs were well met. There were written policies on all aspects of the care of young people and inspectors found these were largely reflected in practice.

The young people themselves were largely positive about the care they received. They said they liked living in the centre. They told inspectors that it was relaxing and fun. One young person, when asked what changes she would like to make to the centre replied "maybe less correcting, but it shows that they care for you". Another young person told inspectors that although she would prefer to be at home "the staff do their best to make you feel at home". Inspectors observed that the staff related to the young people in a patient, cheerful and relaxed manner. The young people also told inspectors they liked living with each other and got on well most of the time. From a review of centre files and conversations with the young people, inspectors found good quality key working sessions with the young people and staff, covering areas such as sexual health and anger management. Each of the young people had three key workers and they saw their key workers as advocates. All the young people spoke well of the food in the centre. Inspectors found it was varied and nutritious. Clothes were purchased as required and were chosen by the young people. The young people had their own bedrooms which they personalised with posters and family pictures.

Family contact

The centre encouraged family contact. One young person was in a shared care arrangement with another centre where her mother and siblings and staff lived. Inspectors found that young people had regular contact with members of their family. This involved time at home, weekend breaks, and phone contact. One parent told inspectors that the centre worked in partnership. The standard on family contact was met.

Administrative files

The content and organisation of care files was generally good. They were and organised in a way that facilitated ease of access for effective management and accountability.

Register

The centre had a register specifying all the information required by the regulations.

Practices that met the required standard in some respect only

Inspectors found that standards were partially met in relation to purpose and function, management and staff supervision, health, social work, children's rights, and maintenance.

Purpose and function and admissions

The centre's purpose and function was met in part. It stated it provided emergency, respite; short medium and long term care for young people, boys and girls. However, the number and age of young people the centre could cater for was not specified. The purpose and function was broad. The manager and staff team were reluctant to refuse a child in crisis. The all encompassing purpose of the centre coupled with the lack of an effective risk assessment of the mix of young people contributed to the difficulties of managing the behaviour of the young people. Inspectors were informed by HSE senior managers that the purpose and function of the centre was under review and inspectors recommend that this is completed as soon as possible.

Management and staffing

The management and staffing was met in part. The centre had a qualified and experienced manager. She was assisted by four social care leaders who acted as shift co-coordinators and were responsible for planning daily activities in the centre. The manager provided order and direction, and was accessible to both the young people and staff. Inspectors formed the view that the manager was respected by both the staff and young people. She was well informed on all aspects of day-to-day care practices and on the needs of the individual young people. There were 16 full time posts including the manager. There was also a full time cook. Inspectors found a dedicated, enthusiastic and cohesive team, the majority of whom were qualified and committed to providing a good service to the young people in their care. This was an experienced stable team with an average of six years child care practice.

Inspectors found that this was a large staff group caring for two young people when compared to similar centres in other parts of the country and recommend that HSE review the optimum use of the staff team. Given how well the team was resourced inspectors were concerned to find problems arising from aspects of the management of the young people's behaviour and this will be discussed in the management of behaviour section below.

Professionals external to the centre spoke of the dedication and resilience of the staff team, and their partnership approach to their work and valued the service they provided. One professional illustrated this by telling inspectors that when one young person was placed in a special care unit where he was detained some months ago, the manager and key workers visited the young person on a weekly basis over a three month period.

Of the 16 staff members, two were male. When asked what changes they would make to the centre, both young people said they would like more male staff. Inspectors urge the HSE to continue in their efforts to recruit male members of staff to ensure gender balance and to provide opportunity for the staff team to model appropriate male/female relationships.

Inspectors found that staff morale was generally good. However some of the staff told inspectors that at times they felt they were insufficiently consulted about aspects of care practice and this affected staff morale to some extent. The centre had the occasional services of a staff facilitator in the past and inspectors advise that this could also be a forum for further discussion on staff empowerment and reflective practice.

Staff supervision

The standard on staff supervision was mostly met. The centre had a policy that formal supervision occurred on a six weekly basis. However it had fallen into abeyance in some cases. Generally formal supervision was seen by the staff team as supportive and a vehicle for accountability. The manager supervised the four social care leaders who in turn supervised the staff team. The centre manager received formal supervision on a six weekly basis from the regional residential manager and had weekly telephone contact. Inspectors recommend that regular formal supervision is provided for all staff in accordance with centre policy.

Other Supports

Staff meetings occurred on a fortnightly basis. These were well attended and often used as an education and training forum in addition to reviewing the needs of the young people. Inspectors advise that minutes of team meetings be recorded in more detail. There was an on call system in place divided among centre managers and regional managers in the HSE DML. There was also a monthly Therapeutic Crisis Intervention (TCI) committee meeting which collated and reviewed all incidents in the preceding month and gave feedback to individual centre managers. The HSE had a policy of supporting staff to obtain required qualifications. At the time of inspection one of the staff team was attending college. Staff had received training in Children First, the *National Guidelines for the Protection and Welfare of Children*, occupational first aid, court room skills and other topics relevant to their work. All newly appointed staff received formal induction.

Monitoring

The standard on monitoring was met in part. The centre had been visited by the monitoring officer on four occasions in the year prior to inspection. She met with the young people and staff and inspected against selected standards. She published a report with recommendations in November 2008. All recommendations had been met by the time of this inspection. She received notification of all significant events including unauthorised absences. The monitoring officer made was available to the manager and staff by phone on a regular basis for consultation. However the frequency of the young people leaving the centre without permission had not diminished. Inspectors recommend an increase in monitoring visits to monitor progress in the management of behaviour and escalate her concerns to senior managers if required.

Health and specialist services

The standard on health was mostly met. The young people had a general practitioner and a choice of male or female doctor. The staff team were aware of the health needs of the young people. Medical records needed to be more ordered. The young people had a medical report but no medical history on file. Inspectors recommend that medical histories be included on care files in accordance with standard 9.2. The centre accessed other medical specialists as required. Inspectors observed that the young people were smoking frequently during the inspection. The HSE should ensure that the centre recommences a smoking cessation programme for the young people.

Children's Rights

The standard on children's rights was mostly met. Young people were informed of their rights on admission and received a young people's booklet outlining these rights. The young people told inspectors that they were consulted about all aspects of their lives, and facilitated to give their views at care plan review meetings. They were consulted about school and training courses. They were also involved in drawing up a daily menu and could choose their own clothes.

The young people and the staff team were aware that they could read their daily log books. Most of the staff team were aware of the children's right to information about themselves held on their care files. Some staff and one of the young people believed they did not have a right to access their care file until they were 18 years of age. Inspectors recommend further training for centre staff and information for young people on this aspect of children's rights. Inspectors recommend a more active approach to access to care records. The young people told inspectors that they would like contact with the Irish Association of Young people in care and inspectors would encourage staff to initiate this.

The young people were confident that their complaints would be dealt with fairly and seriously. Inspectors found that complaints they reviewed had been dealt with appropriately and promptly.

Social work and care planning

The young people had up to date statutory care plans and these were reviewed within statutory time frames.

One young person's social worker visited the centre regularly and knew her very well. The other young person did not have a social worker. The social work team leader was available to respond to any difficulties however because of the lack of a dedicated social worker there was an element of drift in her placement. Inspectors recommend the appointment of a supervising social worker as a matter of priority.

There was a good level of inter-professional work and inter-agency cooperation between the centre and social workers. The social workers told inspectors that in their view the young people were well cared for, communication was very good and they were notified of all significant events. They receive written reports on a weekly basis.

The social workers were aware of the difficulties in managing some aspects of the behaviour of the young people and the risk to which the young people were exposed. They said in interview that the staff team were doing everything that was possible to manage the situation. However difficulties continued. Inspectors recommend, amongst other things, an increase in visits to address this.

One of the two social workers read centre care files. Inspectors recommend that this occurs from time to time in all cases as required by regulation.

Child safety and protection

The staff team interviewed by inspectors had a good knowledge of centre policies and national guidelines and were vigilant and clear about how they would act in the event of concerns about the safety of children. All the young people said they would talk to staff if they were worried about anything. However they were leaving the centre without permission and engaging in risky behaviour such as alcohol consumption and associating with unsuitable peers. A child protection conference had taken place in both cases but the risky behaviour continued. This is further discussed under behaviour management below.

Aftercare planning

Preparation for leaving care was good. Inspectors reviewed key working sessions in the year prior to this inspection that displayed comprehensive training in independent living. However, a key recommendation issuing from the last inspection in 2006 stated: *The HSE should develop a written policy on its aftercare provision, outlining all aspects of support and entitlement for young people leaving care.* Inspectors found during this inspection the HSE ML care policy was still in draft form. This is unacceptable. Inspectors were informed that the HSE had recently appointed a full time coordinator of aftercare. Inspectors recommend that the HSE Draft policy is finalised and implemented as a matter of the highest priority.

Premises

The centre had been subject to a health and safety audit in 2006 and recommendations arising from this had been met. The centre is a three bed roomed house. It has a homely atmosphere and was generally well maintained but needed to be repainted internally and externally.

Practices that did not meet the required standard

The standard was not met in relation to education, garda vetting, behaviour management and fire safety.

Education

The standard on education was not met.

Although the management and staff team placed a high value on education, and had persevered in finding education or work placements and in one case home tuition, the young people were either suspended from school or refused to attend. Both young people had attended school in the past and although there were difficulties were good students. At the time of inspection the young people were getting up late, staying in the centre and refusing to attend school or training. This is unacceptable. Inspectors recommend that the staff team and social workers review and renew their efforts to return these young people to school. Inspectors recommend that the National Education/ Welfare Service are informed and involved in one case.

Vetting

The standard on vetting was not met. Information provided to inspectors showed that there were significant deficiencies in vetting. There were conflicting dates for garda clearances for three of the staff team. One of the staff team commenced work at the centre prior to the receipt of Garda clearance and the required three references.

Inspectors recommend that the centre manager in conjunction with her line manager complete a check on vetting of all centre staff, and in future garda clearance and three references are received prior to the commencement of employment in the centre. Inspectors will review all personnel records of the staff team on the follow up inspection within three months of the publication of this report.

Behaviour management

The standard on the management of behaviour was not met. The centre had a points system and good behaviour earned privileges. The centre's sanctions policies primary focus was to maintain positive relationships. There had been one physical restraint in the year prior to inspection. This was a standing hold of one minute's duration. Inspectors found that the young people were well cared for and that staff related well to them. At times there was a good level of co-operation and an air of affection and fun. The staff who were interviewed said that consistency in the team approach, a good relationship with the young people were the key factors in managing behaviour. The young people had individual crisis management plans.

The staff had serious difficulties in managing behaviours and risk. The combination of the points system and relationship building had worked for some young people in the past. However inspectors had serious concerns about some aspects of the management of behaviour both in the centre and when the young people left the centre without permission. In the year prior to inspection there had been 75 incidents of unauthorised absences involving three young people and 40 of these were overnight. There was concern about alcohol consumption by young people while away from the centre. All relevant people had been informed, including the gardai in line with HSE policy, but the absences continued.

Staff struggled to give the young people routine and structure when they were not attending school or training. In the year prior to inspection some of the young people, at times boys and girls, were staying in each others bedrooms contrary to the direction of staff and staff on duty would remain up all night supervising them. The young people were smoking in their bedrooms and refusing to stop when requested to by the staff team. There were high levels of threats of physical violence, verbal abuse and sexualised language and gestures directed mainly at female staff. At times the staff team had lost control of the group.

There were three reasons for difficulties in the management of behaviour. The admissions committee did not have an effective policy risk assessing the mix of young people in the centre. The staff manager and team had at times lost confidence in their ability to manage some of the behaviours of the young people and there was no overall internal strategy for effectively reviewing, risk assessing, and managing the behaviour of young people in the centre. The behaviour of the young people was reviewed continuously within statutory care planning and reviews risk assessment and behaviour management programmes. However the outcome was the young people were still involved in risky behaviour placing themselves in danger.

While staff told inspectors that they had experienced difficulties and at times morale was low, staff members observed by inspectors contained their feelings and interacted positively with the two young people. The young people themselves were by and large positive about the centre. However further training, direction and support in responding to challenging behaviour is needed. Inspectors recommend a review of the management of behaviour and the management and its capacity to manage behaviour and risk.

Fire safety

The standard in relation to fire safety was not met

The centre did not have written confirmation from a qualified architect or engineer that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.19. The practice of the young people smoking in bedrooms was dangerous. Inspectors recommend the HSE seek the advice of the HSE fire safety officer, to develop a plan to manage the serious risk presented by smoking in bedrooms, while also impressing on the young people that it should cease.

2. Findings

2.1 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		√	

Recommendation:

1. **The HSE DML should review the centre's purpose and function and risk assessment to include the number and age of children cared for in the centre.**

2.2 Management and staffing

Standard

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

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

Recommendations:

2. The HSE DML should ensure that in future Garda clearance is received prior to the commencement of employment in the centre
3. THE HSE DML should audit vetting for all centre staff.
4. The HSE DML should ensure that all staff receive regular formal supervision.

2.3 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		√	

5. The HSE should ensure that there is an increase in monitoring visits to assess progress in the management of the safety and behaviour of young people, and escalate her concerns to senior managers if required

2.4 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		√	

Recommendation:

6. The HSE DML should ensure that centre staff receive refresher training on children's right to information about themselves.

2.5 Planning for children and young people

Standard

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

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

Recommendations:

7. **The HSE DML should ensure that a social worker is appointed for one young person as a matter of priority.**
8. **The HSE DML should ensure that social workers read centre files from time to time.**
9. **The HSE DML needed to sign off their draft aftercare policy and implement it as soon as possible.**

2.6 Care of young people

Standard

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

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

Recommendation:

- The HSE DNE should ensure that management change current practices to support better outcomes for young people.

2.7 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		√	

Recommendation:

- The HSE DML managers should develop comprehensive strategy for reviewing, risk assessing and managing the young people at the centre.

2.8 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

- The HSE DML should review the policy and practice of educational provision at the centre in consultation with the National Educational Welfare service when a young person is not attending school or training.

2.9 Health

Standard

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

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

Recommendations:

- The HSE DML should ensure that in future medical histories are kept on file.
- The HSE DML should develop a smoking cessation programme for young people at the centre.

2.10 Premises and Safety

Standard

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

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

Recommendations:

15. The HSE DNE should ensure that the centre is redecorated internally and externally.
16. The HSE DML should ensure that the centre obtains written confirmation from a certified engineer or qualified architect that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.19.
17. The HSE DML should ensure that the centre manager and fire safety officer formulate a strategy for responding to young people smoking in bedrooms.

4. Summary of recommendations

- 1.** The HSE DML should review the centre's purpose and function and risk assessment to include the number and age of children cared for in the centre.
- 2.** The HSE DML should ensure that in future Garda clearance is received prior to the commencement of employment in the centre
- 3.** THE HSE DML should audit vetting for all centre staff.
- 4.** The HSE DML should ensure that all staff receive regular formal supervision.
- 5.** The HSE should ensure that there is an increase in monitoring visits to assess progress in the management of the safety and behaviour of young people, and escalate her concerns to senior managers if required
- 6.** The HSE DML should ensure that centre staff receive refresher training on children's right to information about themselves.
- 7.** The HSE DML should ensure that a social worker is appointed for one young person as a matter of priority.
- 8.** The HSE DML should ensure that social workers read centre files from time to time.
- 9.** The HSE DML needed to sign off their draft aftercare policy and implement it as soon as possible.
- 10.** The HSE DNE should ensure that management change currant practices to support better outcomes for young people.
- 11.** The HSE DML managers should develop comprehensive strategy for reviewing, risk assessing and managing the young people at the centre.
- 12.** The HSE DML should review the policy and practice of educational provision at the centre in consultation with the National Educational Welfare service when a young person is not attending school or training.
- 13.** The HSE DML should ensure that in future medical histories are kept on file.
- 14.** The HSE DML should develop a smoking cessation programme for young people at the centre.
- 15.** The HSE DNE should ensure that the centre is redecorated internally and externally.
- 16.** The HSE DML should ensure that the centre obtains written confirmation from a certified engineer or qualified architect that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.19.
- 17.** The HSE DML should ensure that the centre manager and fire safety officer formulate a strategy for responding to young people smoking in bedrooms.