



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**Social Services  
Inspectorate**

**A  
CHILDREN'S RESIDENTIAL CENTRE  
IN THE  
HSE WEST AREA**

***INSPECTION REPORT ID NUMBER: 406***

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# **1. Introduction**

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Health Services Executive (HSE), West Area (WA) under Section 69 (2) of the Child Care Act 1991. Patrick Bergin (lead inspector) and Kieran O'Connor (co-inspector) carried out the inspection over a two day period from 28 to 30 of July 2010.

The centre was established in August 2009 as a short-term/emergency residential service following reconfiguration of children's residential services in the area. The centre was located on the outskirts of a large town and structural alterations and repairs were carried out prior to its official opening to make it fit for purpose. It provided four placements for boys and girls, aged between 13 and 17 years of age on admission. There were four young people on the register for the centre. Three of the young people were living in the centre while the fourth was at home by agreement with the social worker.

## **1.1 Methodology**

In this inspection, inspector's judgements are based on evidence of findings verified from several sources. They are gathered through direct observation of the interactions between staff and young people, an inspection of the accommodation, interviews with three young people, the centre manager, four centre staff, relevant HSE personnel and managers. Inspectors also interviewed the monitoring officer and examined records and documents detailed below:

- The centre register
- The centre's statement of purpose and function
- The centre's policy and procedures
- The young people's care plans
- Questionnaires completed by young people
- Questionnaires completed by parents
- The HSE monitoring officer's reports
- The young people's care files
- Administrative files
- Details of physical restraints
- Details of unauthorised absences

## **1.2 Acknowledgements**

The inspectors wish to acknowledge the cooperation of the young people, centre staff, HSE managers and other professionals who assisted in the inspection.

## **1.3 Management structure**

The centre had a manager who reported to an acting principal social worker who had responsibility for alternative care services in the area who in turn reported to a child care manager.

### **1.4 Data on young people**

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

***Listed in order of length of placement***

<b>Young Person</b>	<b>Age</b>	<b>Legal Status</b>	<b>Length of Placement</b>	<b>No. of previous placements</b>
# 1	16	Voluntary Care	1 week	Four residential placements
# 2	14	Voluntary Care	1 month	No previous placements
# 3	15	Voluntary Care	4 months	No previous placements
# 4	16	Care Order	8 months	One foster placement

## **2. Analysis of Findings**

The primary care of people in the centre was of a good quality. Inspectors found that young people were well cared for and in general were positive about their experiences in the centre. Standards that were met included, care of young people, education and monitoring. Areas that needed improvement included, staffing, staff supervision, complaints, planning for young people, safeguarding and child protection, and the premises.

### **2.1 Practices that met the required standard**

#### ***Management***

The centre had an appropriately qualified manager who reported to the principal social worker for alternative care. At the time of the inspection the principal social worker for alternative care was on leave. However another principal social worker in the area who was familiar with the centre and the children met with inspectors during the inspection.

Inspectors found there was an inclusive approach taken by the centre manager and alternative care manager in the provision and development of the service. There was regular contact between the centre manager and line manager and activities and developments in the centre were regularly discussed and reviewed.

#### ***Register***

The centre had an electronic register of all young people that stayed in the centre since it opened in August 2009. The register contained all the statutory required information. There were 19 young people named on the register since it opened with 45 admissions recorded. This reflected the fact that the centre provided respite care to a number of young people and their names appeared on the register each time they received respite there.

#### ***Notifications of Significant Events***

The centre had a system of reporting significant events to social workers, the line manager and HSE monitoring officer. Significant events included unauthorised absences from the centre and behaviours that were of concern owing to the risk they entailed. These included incidents of self harm or physical interventions used by staff to manage crisis situations.

Inspectors were told by social workers they were satisfied that they were kept informed of concerns, in accordance with the standards.

#### ***Training and development***

Inspectors were told by the centre manager that training was available to care staff. This included first aid training, therapeutic crisis intervention (TCI) and child protection. Further training in TCI was due to take place. An

external facilitator was made available to the team to explore the dynamics of the care team and their impact on children availing of the service.

Inspectors found that further training in child protection would benefit the team particularly as the nature of the service involves working with children on an emergency and short term basis who may be in crisis or at risk. Inspectors advise that such training should be undertaken periodically to maintain a high degree of awareness safeguarding and child protection in the team.

### ***Administrative and care files***

Inspectors found there were good recording systems in place that accurately reflected the day-to-day operations of the centre. Care files had individualised sections which made information easy to access. Information which was sensitive to young people was retained in a confidential section. Keyworkers supported young people in accessing their information in an organised and appropriate way following consultation with the authors of reports.

Inspectors found that staff in the centre utilised their own cars to transport young people as the centre did not have a designated centre car. Inspectors advise that a review of the current arrangements should be undertaken to determine the financial differentiation between the current arrangement and the purchase and running of a centre car to attain value for money.

### ***Monitoring***

Inspectors found that this standard was met. The HSE had a monitoring officer who visited the centre to ensure there were adequate care practices in place. There were records of six visits to the centre and two written reports completed (one was in draft). The first report was undertaken in November 2009 and it looked at all of the national standards for residential care. Twelve recommendations were made by the monitoring officer and these related to complaints and sanctions, planning for young people, care of young people and child protection.

In July 2010, the HSE monitoring officer deemed that 10 of the recommendations were met, one partly met and one not met. The monitoring officer found there were difficulties in securing the required information from a social worker and as a consequence deemed this standard to be partly met. A recommendation was made that local procedures for risk assessing and identifying thresholds for reporting child protection concerns be included in the centre child protection policy had not progressed and the recommendation remained unmet.

The HSE monitoring officer was familiar with the young people and care staff in the centre. She met with young people privately to determine their views on their care. She also met with care staff and the centre manager on a number of occasions to consider routines and the care model used in the centre.

### ***Social Worker Role***

The HSE had a process in place where information required by the centre as part of the application for a placement was presented through the centre's application form. Supporting documentation was also required to assist in the decision to determine if the placement request was suitable.

Inspectors found that social workers were active in their contact with centre staff and young people and visited the centre. Social workers met with young people privately in the centre and they were made aware of developments in the young person's life through the significant events record. Social workers also viewed the records and files maintained in the centre about the young person.

Social workers told inspectors they were satisfied that young people were kept safe and well cared for in the centre. The mix of young people in the centre at the time of the inspection was a concern for social workers as two expressed concern about the impact one young person was having on the other young people living there. They were concerned about the escalation of risk taking behaviour of young people in the centre including young people going missing from care and consuming alcohol. This matter is further explored under the sections on individual group living and behaviour management.

### ***Emotional and Specialist Support***

Inspectors found that the centre had developed contacts with a range of specialised services to support the young people's placement in the centre. Supports that were in place prior to the young people being admitted to the centre and these were encouraged and facilitated.

The services linked with the centre include a community-based psychology service and a drug and alcohol addiction service. Other community-based services such as youth and community groups were also involved with individual young people.

Inspectors were told that there was no delay in young people accessing these services. Keyworkers and the centre manager played a significant role in maintaining contact with supporting services. Inspectors found evidence of a positive interdisciplinary and multi-agency partnership in providing young people with care and ensuring their safety.

### ***Preparing for leaving care and discharges***

There were 19 young people on the centre register with 45 entries over the twelve months prior to the inspection. There were multiple admissions and discharges of children and young people placed in the centre on respite. There were 28 placements of young people of periods less than seven days. The core number of young people accessing the centre for short term placements (three to six months) numbered nine with four of these in

placement at the time of the inspection. Inspectors were told that all discharges were planned.

The preparation for leaving care was undertaken by key workers through direct work with each young person. This involved practical preparation such as advice on self-care, maintaining education or training routines and adjusting to changing environments. In one instance it was planned for the young person to return home but due to external circumstances, this did not occur. Foster care was identified as the most suitable alternative and key workers were engaging with the young person in preparing him for the transition.

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

Young people had their own bedrooms which were spacious and decorated to their individual taste and personalised to reflect their interests. There were two sitting rooms and a large kitchen/dining area where staff and young people congregated and interacted. Inspectors found there was a positive interaction between young people and staff. There was a strong emphasis on individual care with individual interests and activities being encouraged.

One young person's birthday was recently celebrated in the centre and he enjoyed the recognition. There was a strong emphasis on outdoor pursuits including kayaking, camping and rock climbing. Young people enjoyed these activities. Inspectors found that individual interests were encouraged and there was a creative approach to ensuring the interests of young people were promoted.

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

The centre had a large kitchen/dining area where staff and young people prepared meals and eat together. Shopping was undertaken by care staff and young people helped from time to time. Inspectors were told that this did not always happen in school term time but during the summer months it was normal for young people to go shopping with staff.

Young people participated in preparing meals and during the inspection one young person was responsible for the preparation of dinner for the staff and young people under the supervision of a staff member. The young person was proud of his accomplishments and there was evidence of a culture of support and encouragement in this area.

There was evidence of ample wholesome food available to young people and young people told inspectors that their individual preferences were considered in the preparation of meals.

### ***Education***

At the time of the inspection all young people were on summer holidays from school. Inspectors found there was a culture of educational attainment in the centre. Young people were registered in schools. One young person who had

sat his junior certificate exam told inspectors that he did not believe he did well in the exams due to poor school attendance.

Due to the function of the centre to take short-term and emergency placement, some young people admitted to the centre during the school year were not attending school locally. Inspectors were told by the centre manager and staff that in spite of the challenges it presented they transported up to four young people to different schools throughout the county.

Inspectors found some information about young people's educational history on their care files. There was evidence that key workers maintained contact with the teachers to determine how young people were progressing in school.

### ***Maintenance and repairs***

The centre manager told inspectors there was no difficulty in responding to items that needed repair which was undertaken by the local HSE technical services department. Inspectors found evidence that requests were responded to promptly.

### ***Accommodation***

The building was of good condition and maintained well. The centre was in operation 12 months at the time of inspection and remedial works had been undertaken prior to the centre opening. It was well furnished and each of the young people had their own bedroom and there was a room in which they could meet their family privately.

While the centre was decorated and maintained at a high level, inspectors advise that young people's views should be sought regarding the rearrangement of furniture and decorating the premises.

## **2.2 Practices that partly met the required standard**

### ***Purpose and Function***

The centre had a written statement of purpose and function which was approved by Donegal local health managers. It outlined the service was for four young people, boys and girls between the ages of thirteen and seventeen who required short-term/emergency placements. The document outlined the necessity to review the purpose and function of the service on an annual basis and identified the centre manager and principal social worker for alternative care with the responsibility for ensuring the statement was reviewed.

The document included key policies and procedures, the referral and admission process and the care and placement planning process. From examination of the centre's register inspectors found that it provided a respite care and outreach service to several young people. Staff were aware of the purpose of the centre, and day-to-day operations reflected this.

Inspectors recommend that the HSE WA review the purpose of the centre considering the diverse aspect of the service which includes, emergency and short-term placements, respite care, and out reach services to children and families in the community, and into account the rapid changes in the admissions and discharges this entails.

### ***Staffing***

The centre had two social care leaders to support the manager in the operations of the centre. There were seven social care workers with the two social care leaders on a nine week rota to provide 24 hour cover in the centre. Two care staff normally worked from 11am to 12 midnight, slept in the centre and completed their shift from 7am to mid day the following day. A third staff member worked a day/evening shift from one to nine or two to ten p.m. This provided for three staff to be on duty most afternoons/evenings.

Inspectors found a resilient staff team with a positive mix of qualifications, life experiences and gender. There was a good rapport between young people and staff and inspectors found that staff shared their own interests and hobbies with young people.

Inspectors were told by care staff that there was no waking staff on duty between midnight and 8am. Inspectors found reports on file of young people having left the centre during the night, a young person inhaling aerosols and concerns about threats of self harm. Staff reported that when they were aware of risks, they remained awake at night and responded to the situation as it developed. The capacity of care staff to supervise young people after a twelve hour shift, respond to risks and situations appropriately was a concern to inspectors.

Inspectors were mindful of the nature of the service, providing emergency placements on a short term basis to boys and girls. The capacity of the staff to be fully aware of the history of a young person admitted to the centre was not possible and inspectors found that a more robust and adequate staffing regimen should be in place at night to keep young people safe and manage the risks associated with such a service.

Inspectors recommend that the HES WA undertake a review and change the staff rota to maximise the deployment of staff and ensure adequate level of staff are available to fulfil the purpose and function of the centre.

### ***Vetting of staff***

Inspectors reviewed staff files and found there was no Garda vetting forms relating to staff on the premises. There was documentation on some staff files from the HSE recruitment department stating that individual vetting was in order. Health Service Executive policy stated that garda vetting was retained centrally. Inspectors recommend that the HSE WA ensure that all staff are appropriately vetted, that the centre manager assures himself that all vetting

is in order and that evidence reflecting this is placed on staff files in the centre.

### ***Supervision and support***

Inspectors found evidence that there were deficiencies in the provision of staff supervision within the centre which related to frequency of supervision, understanding of the role of supervision and the utilisation of the social care leaders to provide supervision to staff.

The centre had a policy on supervision of staff which stated that supervision should occur every six weeks. The centre manager was responsible for the supervision of all care staff. Inspectors found that while supervision did take place, its frequency was not in line with the centre policy. Inspectors found evidence of discussions during the supervision sessions about young people, care practices and staffing issues. The manager told inspectors that due to limited administration support there was a backlog of supervision records to be typed. Staff interviewed by inspectors reported inconsistencies in supervision.

Inspectors recommend the HSE WA reviews staff supervision practices in the centre including the role of the social care leaders to undertake supervision, provides training to staff on the purpose and benefit of supervision, and defines the responsibilities of the supervisor and supervisee in the process. The monitoring officer should periodically review the provision of supervision in the centre.

### ***Children's rights***

Three young people met with inspectors separately and completed a questionnaire about their experiences in the centre. All young people told inspectors that their views were sought about decisions which affect them. One young person told inspectors that he was asked his opinion but that his opinion was ignored by care staff and his social worker. He was unhappy about his ongoing placement in the centre and he held the opinion that he should be placed elsewhere. Other young people stated that staff enquire about their views on food, activities and other routines in the centre. They stated that they would speak with their social worker if there were any issues they needed to discuss. They told inspectors they could talk to their key workers, the centre manager, and their social worker or family member also.

Inspectors were told by the centre manager and staff that there were no complaints on file in the centre. Young people did express dissatisfaction about a range of issues but these were not deemed to be complaints. There was a complaints policy in the centre and it highlighted the need for records to be maintained of all complaints. Two young people told inspectors that they had no complaints. Another had complained about living in the centre and told inspectors that no one was taking his complaint seriously. Inspectors advised staff and the centre manager of the young person's views of his complaint and for the matter to be addressed accordingly.

Inspectors recommend the HSE WA reviews the practice of responding to and recording complaints and expressions of dissatisfaction and that it provides training to care staff on the children's rights to express concerns and or complaints. Inspectors further recommend the HSE monitoring officer reviews the complaint logs periodically to determine that the centre is meeting the standard.

Young people told inspectors that they could view their files. Two young people said they had no interest in viewing what was written about them. Inspectors found positive comments written about each young people's day. Inspectors saw that some young people had signed these entries. This was positive practice. Each file had a confidential section where information not appropriate for viewing by the young people was maintained. There was a policy on access to information which guided and informed staff.

### ***Suitable placement and admission***

The centre was operating 12 months at the time of the inspection. There were three young people living in the centre with a fourth at home with permission. Social workers interviewed by inspectors said that in general they were satisfied with the placement of the children but highlighted concerns about the impact of one young person's behaviour on the young people living in the centre. Concerns were raised by inspectors following the inspection fieldwork about the risks to one young person of his own behaviour and the impact on others living in the centre. A strategy involving a range of services was developed to address the immediate concerns identified. This issue will be discussed further in the report in the section on the section care of young people.

The centre has a statement of purpose and function which included the procedures for the admission in a planned way. The referral process was made through the centre's placement request form and a risk assessment was incorporated into the process. The local HSE placement forum for the area considered all placement requests.

When an emergency placement was required the principal social worker and the centre manager agreed on the admission and the standardised process of gathering information and undertaking the risk assessment was completed. The emergency placement was considered at the next placement forum meeting.

Prior to the inspection an emergency placement was accepted into the centre. Inspectors were told that there were reservations amongst the centre staff and management as to the appropriateness of the placement considering the young persons needs and the mix of young people in the centre. Inspectors were told by centre manager and staff that the young person was admitted on the basis of necessity rather than suitability.

Inspectors were concerned about the capacity of the centre to formulate decisions on the suitability of young people to be admitted to the centre on the basis that it provides emergency and short-term placements. This will be developed further under the section on care planning.

Inspectors found that young people were aware of the reasons for their placements. Although one person expressed his unwillingness to remain in the centre he was aware of the reason for admission.

Inspectors found that the centre admission policy took account of the need to protect young people in group living situations. There was evidence that staff practices were developed to support safe care. However, there was also evidence found that the staff team could not keep some young people safe when one young person presented challenging behaviour.

Inspectors recommend that the HSE WA undertake a review of the practice in respect of admissions, and the capacity of the service to meet the needs of the young people placed in the centre considering the resources and systems available to the centre.

### ***Statutory care plans and reviews***

Inspectors found that the young people in the centre had plans prepared by social workers following admission to the centre. These plans were not consistent with the statutory care plan as required under the *Child Care (Placement of Children in Residential Care) Regulations 1995 Part IV*. For example, in their preparation there was no formal process of consultation with young people, parents and significant others.

Inspectors found that three of the young people had statutory care plan reviews and there was an independent chair to facilitate this process. Inspectors were concerned that the reviews did not pick up on the fact that the original plans were not compliant with regulatory requirements. Inspectors were concerned that a considerable amount of time of the young person's placement had elapsed before a review took place in which all relevant parties were consulted.

Inspectors found evidence of placement plans on young peoples care files. These provided clarity to the staff on the role and focus of the placement. While this focus should be based on actions formulated at a care plan meeting, inspectors were concerned that these were decided without appropriate consultation or agreement by parties relevant to the case.

Inspectors recommend that the HSE WA comply with the requirements the *Child Care (Placement of Children in Residential Care) Regulations 1995* regarding care planning and care plan reviews.

### ***Contact with families***

One of the centre's stated aim and objective was to develop, promote and maintain appropriate relationships with the family and the community of each young person in care. Inspectors were told that some parents have visited the centre and on some occasions access between parents and young people was facilitated there.

Social workers told inspectors that the centre staff supported and encouraged positive contact between young people and their families. Examples were cited where contact between young people and parents did not occur due to relationship difficulties or because it was an agreed strategy as part of the review care plan. One parent told inspectors she knew her son did not want to see her, she didn't know where the centre was as she had never been there. She told inspectors she was not happy with the amount of information she received about aspects of her son's care.

The parent of another young person told inspectors that there was a shared care arrangement between her and the centre, with the young person staying at home on a regular basis. Inspectors were told that this was a positive arrangement however centre staff acknowledged it would be difficult for the parent to care for the young person on a fulltime and permanent basis at home.

The centre provided respite placements for young people and the level of contact between parents/carers and the staff was ongoing and regular. As part of the out reach service the staff also engaged with young people's parents in their own homes.

While there was regular and positive interaction between staff and families associated with the respite and outreach service, inspectors recommend that an examination should be undertaken of the type and level of contact between young people living in the centre and their families. Particular consideration should be given to the spontaneity of contact, the view that the centre is the home of children and visitors need to be restricted and the impact of families and friends calling to the centre on other young people living there.

### ***Supervision and visiting of young people***

Each of the young people in the centre had a supervising social worker who maintained contact with the centre staff and young person. The preparation of care plans and review care plans in line with the Child Care (Placement of Children in Residential Care) Regulations 1995 and the standards did not always occur.

The centre maintained a record of social worker visits and contacts. Records were also maintained of any actions to be taken as a result of these visits. Inspectors recommend that the HSE WA comply with the requirements of

care planning and care plan reviews as outlined in the *Child Care (Placement of Children in Residential Care) Regulations 1995*.

### **Managing behaviour**

The centre had a written policy for responding to inappropriate behaviour and assisting young people develop positive ways of dealing with their experiences of everyday life. Therapeutic Crisis Intervention (TCI) is the agreed intervention for responding to an escalating crisis and acting out behaviour. Each of the young people has an individual crisis intervention management plan (ICMP) which identifies possible triggers to problematic behaviour and the plan identifies the intervention allowed and those to be avoided by staff in managing an escalating situation.

Risk assessments were undertaken when young people were admitted to the centre and these assessments incorporate known risks and identified responses of the young person prior to admission.

Inspectors were told by the centre manager and staff of risks associated with young people's behaviour including leaving the centre at night without permission or knowledge of staff, solvent abuse, threats of self harm and acting out and destructive behaviour. Inspectors were also told that there were periods of time when the capacity of the staff team to safeguard children in the centre was of concern due to the challenging and negative behaviour displayed by them.

Inspectors were told that the interventions and approach adopted by staff helped to reduce the risks however the changing population of young people in the centre had helped to reduce the risks further. Inspectors noted this view however they were also mindful that the changing population of young people could also be determined as a contributing factor to the crisis.

Following the field work inspection, inspectors became aware of a crisis developing in the centre where a young person's behaviour was deemed to be of high risk. The impact this behaviour had on other young people in the centre was also of concern. Inspectors were concerned about the capacity of the centre to keep young people safe at that time. Inspectors found that significant personnel associated with the young person and the centre were on leave during this period. Following inspectors contact with senior HSE managers in the area to raise awareness of the concerns, a plan was established to address the immediate risks and a date set for HSE managers to review and agree a strategy to progress the ongoing issues.

Inspectors were told that due to the escalating crisis in the centre, a temporary arrangement had been agreed to provide staff at night. This response coincided with a recommendation from the inspectors to undertake a review and change the staff rota to maximise the deployment of staff and ensure an adequate level of staff were available to fulfil the purpose and function of the centre.

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

Inspectors found there was awareness amongst the centre staff of the ethnic and cultural diversity in the group of young people in the centre at the time of the inspection. For example, on one case arrangements were in place to access an interpreter for a young person's mother to communicate with staff.

Inspectors were told that staff had sought information on the religious upbringing of the young people but had not sought a view from parents as to their wishes in the matter. Inspectors recommend that parent's wishes are sought and recorded on the child's file.

Inspectors found that centre manager and staff were unclear about the placement in the centre of children with disabilities. Inspectors advise that consideration is given to the profile of young people that may be catered for in the centre considering the mix of young people, the structure of the premises and the skills of the staff team.

### ***Restraints and absence without leave***

The centre utilises TCI as the management technique to respond to escalating behaviour. There was a physical intervention component to TCI. Crisis Intervention Management Plans (ICMP) identified what physical intervention was acceptable and not acceptable depending on the information available about the young person and the degree of risk evident.

Inspectors found references on one young person's ICMP that physical restraint should not be initiated due to previous abuse experienced by the young person. The option to negotiate with the young person was cited as the preferred and only option to respond to physical outbursts. The manager of the centre told inspectors there was no physical restraint in the centre since it opened. The manager stated that negotiation with a young person was the preferred approach.

Inspectors commend the centre staff for the approach undertaken to date. However, inspectors were also concerned that the volatile nature of some young people in the centre may necessitate physical intervention by staff. While all staff were trained in physical interventions as part of TCI, inspectors recommend that a review of the behaviour management policy and practice be undertaken. This review should consider the approaches to be taken by staff when negotiation with young people does not work and there is imminent danger to the young person, other young people or staff.

The centre maintained a record of instances when young people were missing from care. In the 12 months leading up to the inspection, three young people were missing on 15 different occasions. One young person was missing on 10 of the 15 reported occasions, for periods between three hours and three days. The centre used the HSE/Garda Siochana protocol for reporting children missing from care and measuring the level of risk associated with each absence. Inspectors were concerned that two specific instances where a

young person was missing from the centre at night were not included in the information provided to the inspectors.

Inspectors recommend that the HSE WA ensures that appropriate records are maintained of young people missing from the centre and that they are reviewed periodically by the HSE monitoring officer.

### **Safeguarding**

The centre had a written policy on child protection and safe care practices. The safe care policy included a system to ensure that all care staff had read the policies of the centre. The policy stated that *Children First, Guidelines on the Protection and Welfare of Children 1999* training would be provided to all staff. The policy highlighted the need for staff to ensure that their interactions with young people were appropriate to their needs and that there was an awareness and appropriate response to instances of bullying or any other concerns identified. The policy addressed some aspects of staff working alone with young people and the need to assess levels of risk.

Inspectors found evidence of an awareness of good safeguarding practice amongst staff. This was of particular note in regard to the young people in the centre. Inspectors were concerned about the awareness of staff in regard to safeguarding practices while engaged in outreach work. Inspectors were concerned that staff could be asked to address issues outside work hours and this could lead to unsafe practice. Inspectors recommend that direction and guidance is provided on professional boundaries between staff and young people in the community are issued to staff and that monitoring systems are put in place to ensure that such interactions remain appropriate and safe.

Inspectors were also concerned that there were deficiencies in the information retained in the HSE WA in regard to vetting of care staff. Inspectors have made a recommendation in respect of this matter under the section on vetting. Full vetting of staff is a key aspect of best safeguarding practice.

### **Child protection**

Inspectors were told by centre staff and the manager that *Children First National Guidelines for the protection and Welfare of Children 1999* was the child protection policy used in the centre. Staff were trained in the policy and further training was planned.

Inspectors were told that there were no outstanding child protection matters in regard to young people in the centre. Some issues had been reported to social workers through the significant events reports. One report related to a young person making reference to a child protection concern which occurred some years previous to her placement. Although this matter was reported to the HSE social work department, inspectors were concerned to find that the standard reporting form which is a feature of the Children First guidelines was

not used. As a consequence it was unclear to centre staff and manager as to the status of the information or the actions taken to assess the report.

Inspectors found that the centre manager and centre staff were unclear about their individual responsibilities to report child protection concerns and the procedure that followed from such reports. Inspectors recommend that the child protection policy is revised and sets out more directly the responsibility of centre staff and centre manager and their role in the local child protection procedures.

### **Health**

There was evidence on each young person's care file that they had a medical assessment on admission to the centre. Each of the young person's files had a medical section. Some information was available on file in regard to dental treatment of young people. Each of the young people had access to a general practitioner and there were medical consent forms signed by their parents.

There were records of prescribed and non-prescribed medication issued to young people. This was up-to-date and reviewed by a designated member of staff on a regular basis. Inspectors found evidence of staff accessing specialised medical services to address physical and sexual health services for young people. Specialised services were also available to support young people with alcohol dependency/misuse.

The centre had a non-smoking policy. However young people smoked cigarettes at a designated location at the rear of the centre. Inspectors found evidence that staff smoked with young people and this was contrary to centre policy. Inspectors recommend that the HSE WA undertake a more rigorous monitoring of centre staff's compliance with the smoking policy and run programmes to inform young people on the harmful effects of smoking.

### **Safety**

The centre did not have a unit vehicle and staff used their own cars for transporting young people. Staff were requested to ensure that they had adequate insurance in place and only staff with full driving licences were permitted to use their cars for work duties. There was no evidence available confirming that all staff complied with this requirement. Inspectors recommend that the HSE WA ensures that all staff have adequate insurance and full valid driving licence for the use of their cars when performing their work duties. Inspectors recommend that documentary evidence is maintained and reviewed annually to ensure compliance.

The centre had undertaken a health and safety audit in September 2009 and this was due to be reviewed in September 2010. There was evidence found that the audits recommendations were implemented in a timely manner. Medication was maintained in a locked cabinet in the staff office. Inspectors were concerned with the level of risk-taking behaviour demonstrated by some young people in the centre including self-harm and unauthorised absences at

night. Inspectors found that there was a need for greater staff awareness about potential of self-harm. Inspectors recommend that the health and safety statement and risk hazard identification process documentation include these and other risks associated with the care of vulnerable and volatile young people.

### ***Fire safety***

The HSE WA had written confirmation from an architect dated 2005 indicating that an inspection was carried out at the centre. It stated that as a domestic type dwelling it had been confirmed by the local county council Fire Service Department that a Fire Certificate was not required. The document confirms that fire detection and alarm systems were in place, emergency lighting installed, provision of fire resistant doors to protect stairwell and fire extinguishers and fire blanket are also available on site. The view held was that the fire safety works were satisfactory.

The report indicated that the general condition of the premises was not inspected and neither were fixtures, fittings or furniture. Further correspondence dated June 2010 confirmed that minor works were carried out to the house in 2007/8 but that these works did not adversely affect the fire safety provision within the premises.

Inspectors found that there was evidence that aspects of the *Child Care (Placement of Children in Residential Care) Regulations 1995 Part III Article 12* were met but not in full. The need for furniture and fittings to be compliant with fire safety requirements remained outstanding. Inspectors recommend that the HSE WA ensure that there is written confirmation that all statutory requirements relating to fire safety and building controls are fully complied with.

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

All of the standards in the centre were either met or met in part met.

### 3. Findings

#### 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 WA should review the purpose of the centre considering the diverse aspect of the service which includes, emergency and short-term placements, respite care, and out reach services to children and families in the community, and take into account the rapid changes in the admissions and discharges this entails.

#### 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 WA should revise the staff rota to maximise the deployment of staff and ensure adequate levels of staff are available to fulfil the purpose and function of the centre and provide safe care.

3. The HSE WA should ensure that all staff are appropriately vetted and that the centre manager assures himself that all vetting is in order and that evidence is placed on staff files reflecting this.
4. The HSE WA should review staff supervision practices including the role of the social care leaders to undertake supervision, provide training to staff on the benefits of supervision and outline the responsibilities of the supervisor and supervisee in the process. The monitoring officer should periodically review the provision of supervision in the centre.

### 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	√		

### 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:

5. The HSE WA should review the centre’s practice in responding to children’s complaints. The HSE monitoring officer should review the centre’s complaints logs periodically to ensure that the centre is meeting the standard.

## 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	√		

### Recommendations:

6. The HSE WA should undertake an examination of the type and level of contact between young people living in the centre and their families.
7. The HSE WA should undertake a review of the centre's admissions, processes and the capacity of the service to meet the needs of the young people availing of the centre.
8. The HSE WA should comply with the requirements for care planning and care plan reviews as outlined in the *Child Care (Placement of Children in Residential Care) Regulations 1995*.

## 6. Care of young people

### Standard

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

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

### Recommendations:

9. The HSE WA should review the profile of young people that may be catered for in the centre considering the individual needs of young people, the structure of the premises and the skills of the staff team.
10. The HSE WA should review the behaviour management policy and practices in the centre to ensure risks to the individual young person, other young people in the centre and staff are managed safely and appropriately.
11. The HSE WA should ensure that appropriate records are maintained of young people missing from the centre. The HSE monitoring officer should review the centre's practice in respect to all unauthorised absences.

## 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 WA should ensure that the centre's child protection policy is reviewed and clear direction and guidance are given to the centre manager and centre staff regarding their roles in the local child protection system.

## 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	√		

## 9. Health

### Standard

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

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

### Recommendation:

- The HSE WA should undertake a more rigorous monitoring of centre staff's compliance with the smoking policy and run programmes to inform young people on the harmful effects of smoking.

## 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:

14. The HSE WA should ensure that the health and safety statement and the risk hazard identification process include all risks associated with the care of vulnerable and volatile young people including self-harm and unauthorised absences.
15. The HSE WA should ensure that there is written confirmation for the centre from a certified engineer or qualified architect that all statutory requirements relating to fire safety and building controls are complied with in accordance with standard 10.19.

## 4. Summary of recommendations

1. The HSE WA should review the purpose of the centre considering the diverse aspect of the service which includes, emergency and short-term placements, respite care, and out reach services to children and families in the community, and take into account the rapid changes in the admissions and discharges this entails.
2. The HSE WA should revise the staff rota to maximise the deployment of staff and ensure adequate levels of staff are available to fulfil the purpose and function of the centre and provide safe care.
3. The HSE WA should ensure that all staff are appropriately vetted and that the centre manager assures himself that all vetting is in order and that evidence is placed on staff files reflecting this.
4. The HSE WA should review staff supervision practices including the role of the social care leaders to undertake supervision, provide training to staff on the benefits of supervision and outline the responsibilities of the supervisor and supervisee in the process. The monitoring officer should periodically review the provision of supervision in the centre.
5. The HSE WA should review the centre's practice in responding to children's complaints. The HSE monitoring officer should review the centre's complaints logs periodically to ensure that the centre is meeting the standard.
6. The HSE WA should undertake an examination of the type and level of contact between young people living in the centre and their families.
7. The HSE WA should undertake a review of the centre's admissions, processes and the capacity of the service to meet the needs of the young people availing of the centre.
8. The HSE WA should comply with the requirements for care planning and care plan reviews as outlined in the *Child Care (Placement of Children in Residential Care) Regulations 1995*.
9. The HSE WA should review the profile of young people that may be catered for in the centre considering the individual needs of young people, the structure of the premises and the skills of the staff team.
10. The HSE WA should review the behaviour management policy and practices in the centre to ensure risks to the individual young person, other young people in the centre and staff are managed safely and appropriately.

11. The HSE WA should ensure that appropriate records are maintained of young people missing from the centre. The HSE monitoring officer should review the centre's practice in respect to all unauthorised absences.
12. The HSE WA should ensure that the centre's child protection policy is reviewed and clear direction and guidance are given to the centre manager and centre staff regarding their roles in the local child protection system.
13. The HSE WA should undertake a more rigorous monitoring of centre staff's compliance with the smoking policy and run programmes to inform young people on the harmful effects of smoking.
14. The HSE WA should ensure that the health and safety statement and the risk hazard identification process include all risks associated with the care of vulnerable and volatile young people including self-harm and unauthorised absences.
15. The HSE WA should ensure that there is written confirmation for the centre from a certified engineer or qualified architect that all statutory requirements relating to fire safety and building controls are complied with in accordance with standard 10.19.