



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**A**

**CHILDREN'S RESIDENTIAL CENTRE**

**IN**

**HSE Dublin Mid Leinster**

***INSPECTION ID: 409***

**Fieldwork Date: 14<sup>th</sup>, 15<sup>th</sup> & 22<sup>nd</sup> July 2010.**  
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# 1. Findings

## Introduction

The Health Information and Quality Authority Social Services Inspectorate carried out an unannounced inspection of a children's residential centre in the HSE DML Dublin South West Area. 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 14 15 & 22 of July 2010.

The centre was located in a six bed-roomed detached house surrounded by attractive countryside, near a small town some miles from the suburbs of Dublin. The centre was established to provide a short-term emergency access service for children and young people aged between 12 and 15 years of age on admission. Its purpose was to act as a place of safety for children pending a full social work assessment of risk or where children are awaiting foster care, or emergency respite care to prevent home, or foster placement breakdown.

The centre manager gave approval for admissions in consultation with the coordinator of children's residential services. In the event of the refusal of a place in the centre the referring social worker could appeal to the HSE DML central referral committee.

The centre was a new service that began strategic planning and policy formulation in January 2009 and commenced the service in November 2009. This was the first SSI inspection of the centre. At the time of inspection there was one child registered as living in the centre. However he had returned home some days before therefore there were, de facto, no children living in the centre at the time of the initial inspection fieldwork. Attempts were made by the centre to contact social workers of young people who had stayed in the centre in the recent past to invite them to meet with inspectors. This had not proved possible. A parent of one of the young people did meet with inspectors but inspectors were informed that her child did not wish to attend at this time. However one of the inspectors returned to the centre two weeks after the inspection and spoke with three young people who had subsequently come to live in the centre.

The main finding from this inspection was that this was a well run centre and the overall standard of care was good. The centre staff had experienced some challenges since opening in developing into a cohesive staff team but had progressed well by the time of inspection. There were also challenges in managing some of the young people's behaviour but the team had remained focused and resilient. There was a warm and relaxed, homely atmosphere in the centre.

While this report outlines a number of recommendations in relation to formal staff supervision, unauthorised absences, aspects of child protection, written care plans, inspectors commend the management and staff for the quality of care provided to the young people in the centre.

### 1.1 Methodology

Inspector's judgements are based on an analysis of findings verified from several sources including: evidence gathered through observation of practice, examination of records and documentation, an inspection of accommodation, an interview with three young people, one parent, the manager, and acting manager, six child care workers, two social workers and a team leader. Inspectors also conducted a telephone interview with a guardian ad litem for one young person.

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

- The centre's statement of purpose and function
- The centre's policies and procedures
- The young people's care plans and care files
- Census form on staff
- Census forms on young people
- Staff personnel files
- Questionnaires completed by, young people, care staff and social workers
- Administrative records
- Details of physical restraints in the past year(6)
- Details of unauthorised Absences in the past year(68)
- The centres fire register
- The centres register
- Car and building insurance

## **1.2 Acknowledgements**

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

## **1.3 Management structure**

The centre is managed by centre manager and line managed by the HSE regional children's residential services coordinator who in turn reports to the general manager in the Dublin South West Local Health Area.

## **1.4 Data on young people**

At the time of inspection, the following young people were registered as living in the centre:

<b><i>Young Person</i></b>	<b><i>Age</i></b>	<b><i>Legal Status</i></b>	<b><i>Length of Placement</i></b>	<b><i>No. of previous placements</i></b>
1 male	13	Voluntary care	4.5 weeks	1 short term foster care 1 emergency residential care
*1 male	13	Voluntary care	2 weeks	none
*1 male	13	Care order	2 weeks	3 foster placements
*1 male	14	Voluntary care	1 week	Respite foster care.

**\* Young people interviewed subsequent to inspection**

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

### *Care of young people and group living*

The standard on care of young people was met. There were written policies on all aspects of the care of young people. In general, inspectors found that practices were good and that the young people were cared for well. The relationship between the staff team and the young people was good. The staff team were well aware about what constituted good care practice and told inspectors that one of their most important tasks was to quickly develop a good relationship with young people and ensure that they were as comfortable and happy as possible given the circumstances in which they found themselves, emphasising the value of discussion and negotiations when dealing with difficulties.

The young people told the inspector that they had a room to themselves which was spacious and they could personalise it with photographs and favourite bands. Two young people said that the staff were good listeners. The young people told the inspector that they were treated really well and were respected in the centre. One young person said that he felt bedtime was too early during the summer months, he raised this with the staff team who agreed and extended bedtime an extra half hour. All the young people said that the staff were kind, considerate and fair. Two young people said the acting centre manager was very caring, kind and good fun. Inspectors found that the provision of food was very good. It was varied and nutritious. There was a policy of staff and children having meals together where practicable and children had easy access to a snack between meals.

There was a commitment to involving young people in activities and leisure pursuits such as football, horse riding and music outside the centre and the centre was well located for such activities. The staff team interviewed told inspectors that birthdays and achievements were celebrated in the centre. Inspectors found from a perusal of centre files that there was an emphasis on focused work with the young people. There was evidence that the care staff managed the key working role well and coordinated inputs from other agencies and professionals.

### *Management and staffing*

The standard was mostly met. The 17 staff posts comprising a qualified and experienced manager, twelve permanent members on the staff team, a house keeper and three whole time temporary staff. At the time of inspection the permanent manager was on annual leave. However commendably, she returned to the centre and made herself available for interview as part of the inspection. She was a very experienced professional who was well informed about all aspects of child care and in particular of the services she provided to young people in the centre. She was described by professionals external to the centre variously as focused, upfront, decisive, and child centred. She was assisted by an acting manager, who managed the centre when the manager was on leave. Both the manager and the acting deputy manager were seen by the staff team and other professionals as motivated dedicated and committed to the young people in their care. The staff team interviewed told inspectors that they provided good leadership and direction to the team and had their confidence and loyalty.

There was no formal deputy management post on the staff team. This position needs to be regularised.

At the time of inspection, inspectors found a dedicated, well qualified team committed to providing a good service to young people. They presented as a stable experienced and competent group with an average length of service of eight years. The service they provided was highly valued by professionals external to the centre.

### *Contact with families.*

Inspectors found from staff interviews and centre records that access to family was good. Young people told inspectors that they had contact with their parent's siblings and extended family where appropriate. A parent of one of the young people told inspectors she would have liked more contact and to have visited more often. However she told inspectors she did not drive a car so this restricted her visits as the centre was quite a distance from her home.

### *Administrative and care files.*

The standard on administrative files was met. Inspectors found there were good recording systems in place reflecting the day to day operations of the centre. The content and organisation of the care file, log books and other records was of a good standard written in a respectful tone. Inspectors advise discontinuing the use of the word resident, and just refer to children or young people living in the centre. There was a section in the log book that focused exclusively on the subjective feelings of the child. This was good practice. Inspectors advise that some of the recording in the log book could be a little more succinct. Overall the filing system was coherent, securely maintained, and organised in a way that facilitated ease of access for effective accountability.

### *Staff Supervision and support.*

The standard on supervision was mostly met. There was a commitment to supervision and staff support. The staff team were well supervised on an informal basis. Inspectors examined a sample of records and found that when formal supervision occurred it was of good quality and well recorded. There was an emphasis on the needs of young people and the support and development of the staff team. However formal staff supervision had fallen into abeyance in some cases. The centre policies on formal supervision needed to be revised to ensure that it specifies the frequency and duration of formal supervision. Team meetings were occurring on a weekly basis were well attended and inspectors judged that they were very child centred.

Some of the staff team had been in contact with the HSE employee assistance service after dealing with a stressful work situation and found the service they provided very supportive and helpful. The centre manager had formal group supervision with the regional residential services co-ordinator monthly in conjunction with other centre managers in the HSE DML area. Inspectors judged that this was valuable but insufficient. The centre manager needs to receive regular individual formal supervision with her line manager as required by the standards and best practice. The line managers in turn, kept the general manager informed about progress in the centre.

### *Training and other supports*

All the staff team had the required qualifications. A majority also had a wide variety of qualifications to degree and post graduate level in art therapy, social work, counselling, psychology, therapeutic child care and other areas relevant and valuable to their work. They also attended training in drug awareness, relationships and sexuality, first aid, child protection, fire safety and therapeutic crisis intervention training (TCI). They also attended internal training in the development of the centres policies and other topics relevant to their work. This is good practice. One of the staff team was responsible for training and ensured that all newly appointed staff received formal induction training. Some of the staff team who had experienced such an event told inspectors the support of the centre managers and colleagues, and in particular the centres external line manager was of most value during those difficult times.

### *Education*

The standard on education was met. This inspection took place in the summer months when the young people were on holidays. However, inspectors found that the staff team highly valued education as a vehicle for enhancing self esteem and securing the young peoples future. The centre had a comprehensive written policy on education. Inspectors were told that the children who resided in the centre and were attending school at the time of their placement remained in their current school. Inspectors found evidence that school attendance was maintained in the great majority of cases. The acting centre manager told inspectors that staff insured that this occurred either by bringing the children themselves or ensuring that the social workers had a plan in place for this to occur regardless of the geographical location of the school. When a young person was not attending school prior to placement it was centre policy to do individual school work with the child and proactively encourage the child to return to school in conjunction with the supervising social worker. Three young people told inspectors that one of the golden rules of the centre was that young people must attend school. Inspectors found evidence that following admission, the staff team began working with each young person to establish an educational programme based on the young people needs at the time. The programmes have included art and research projects, in house educational activities for writing, reading, maths and history.

### *Vetting*

Inspectors were informed that all of the staff team at the centre had Garda clearance and the required references. Inspectors perused a sample of staff personnel files and found that these files met the required standards.

### *Insurance*

The centre provided inspectors with documentary evidence that they were adequately insured.

### *Register*

The centre had a register which contained the information required in the Child Care(Placement of Children in Residential Care) regulations 1995 Part IV Article 21.

### *Safety statement & Fire safety*

The centre had a safety statement and a risk assessment completed on 2<sup>nd</sup> November 2009. Inspectors found evidence that fire drills were occurring on a regular basis and fire extinguishers were checked in the year prior to inspection.

The HSE DML possessed written confirmation from an architect that all requirements in relation to fire safety and building control have been complied with as required by standard 10.19.

## ***Practices that met the required standard in some respect only***

Inspectors found that standards were partially met in relation to aspects of purpose and function, written care plan, aspects of health service development, child safety and some minor internal and external environmental improvement.

#### *Purpose and function and admissions*

The centres purpose and function was mostly met. Its purpose was to provide short term residential care for children and young people, boys and girls, aged between 12 and 15 years of age on admission. The centre was established to provide a short term emergency access service for children and young people located in the Dublin Mid-Leinster region. Its purpose was to act as a place of safety for children pending a full social work assessment of risk or where children are awaiting foster care, residential placement or emergency respite care to prevent home, and foster placement breakdown.

Inspectors found that this was occurring in practice in the great majority of cases and was seen as valuable by professional external to the centre. However the purpose and function need to be reviewed in relation to changing the minimum age of children on admission from twelve years to thirteen years of age as required by the Department of Health and Children policy on children 12 years and under in residential care which concludes the overriding policy is that children aged 12 years and under should not be placed in residential care save in exceptional circumstances.

#### *Health and specialist support*

The standard on health was mostly met. All the young people received a medical examination as close as practicable to admission. Each young person had a general practitioner. The staff team were aware of the health needs of the young people. Medical records were good. The young people could either go to their local general practitioner or attend a practice in the town that had a particularly good on call service and were very responsive to the needs of the young people at the centre. The centre accessed other medical specialists as required. The centre had good access to hospital services and could consult with a principal psychologist employed by the HSE DML from time to time. Each young person was linked into the child and adolescence mental health in their local area where necessary. However, it did not have a psychologist to provide specialist discrete service to the centre. Given the complex nature of the service provided by the centre, inspectors recommend the development of more localised and discrete child psychology service to the centre.

#### *Notification of significant events*

The standard was mostly met. The centre had a clear system for the notification significant events and records of these notifications were maintained. External professional interviewed were satisfied that notifications were made in a prompt manner.

However, inspectors were told by the guardian ad litem for one of the children that when she asked for copies of notifications she was told that she had to receive these from the child's social worker. This is an independent officer of the Court appointed by the Court who has authority to request information about significant events without reference to the social work service. Inspectors recommend that the guardian ad litem receives records of significant events directly and expeditiously as requested.

### *Suitable placement and admissions*

This standard was mostly met. There have been 67 initial inquiries by social workers of which 22 became formal referrals since the centre opened. Eighteen of those referred young people were considered suitable and came to live in the centre. Subsequently four of these referrals were deemed unsuitable as they became more known to the staff team. The average length of stay in the centre was five weeks. Inspectors were told that all but one had planned discharges.

At the time of the initial inspection there was one child registered as living in the centre. However he had spent only four days at the centre before going missing without permission. It quickly became apparent that given his level of risk taking behaviour the centre was not equipped to cater for his needs. Initially he was identified as being suitable for mainstream residential care but his behaviour indicated that he was in need of a more specialist service. Although inspectors were told that every case was risk assessed prior to obtaining a placement in the centre there was insufficient risk assessment information available to the centre in this case. Because the consequential risks that emerged once the placement had commenced a decision had been made that pending the resolution of one young person's placement no other young person could be placed in the centre. This meant that at the time of inspection a centre with a skilled staff team had no children in the centre for two weeks. This is a significant economic cost to the exchequer in the current economic climate of very scarce resources. Inspectors recommend that the risk assessment tool is reviewed, refined and implemented fully. Comprehensive background information provided to the centre is a crucial aspect of the risk assessment.

### *Behaviour management and unauthorised absences*

Inspectors found from records and interviews with the staff team that the young people were well cared for and that staff related well to them. The staff team told inspectors that a good relationship with the young people, and an understanding of them and their families was the key factor in managing behaviour. This was done through listening to the young people and promoting positive values such as a sense of fairness and respect for others. Each of the young people had an individual crisis management plan (ICMP). Sanctions were infrequent minor and proportional and experienced as fair by the young people interviewed by inspectors. There was a strong emphasis on the therapeutic aspects of TCI and it was implemented thoughtfully. There had been a review conducted by the centre and overseen by the line manager of a sample of significant events (SENS) numbered 46 to 65 since the commencement of the service in the centre published in July 2010. This identified some deficits in managing behaviour such as staff inconsistencies because of the newness of a dynamic environment, staff needing to take a lead role in some actions and not rely on other professionals, more comprehensive recording on SEN forms and actions to be agreed and taken such as more management support and staff morale to be protected and enhanced. Inspectors judged that this was good mechanism for accountability and reflective practice.

There were 68 unauthorised absences since December 2009 involving seven young people. The centre maintained a record of instances when young people went missing from the centre. The centre used the HSE Gardai Siochana protocol for reporting children missing and measuring levels of risk associated with these instances. Some of the instances were of short duration of an hour or less. However some involved a number of days and in one instance the child who was only nine years of age went missing overnight. Some of the young people were involved in inappropriate and high risk activities with adults known to the gardai. Inspectors recommend that every effort is made to decrease the level of unauthorised absences in the centre.

### *Physical restraint*

There had been six physical restraints and six standing holds involving three young people in since the commencement of the service in the centre. The centre had a policy of physical restraint as an intervention of last resort, and in accordance with an awareness of the medical condition of the young person. Each young person had an individual crisis management plan that included whether the young person could be restrained or not. All appropriate professionals external to the centre were notified in each case and all were reviewed by a review committee in accordance with centre policy.

### *Children's Rights*

The standard on children's rights was mostly met. Inspectors were told by the manager that it was centre policy that the young people had been informed of their rights on admission and they were given a booklet outlining thee rights. This booklet was developed specifically by the HSE DML area and inspectors found that it was thorough in relation to information about residential care and children's rights. It was a very well produced and written in a sensitive and child friendly way.

Key workers were assigned to each young person prior to their arrival to the centre. It was centre policy that generally young people were consulted about all aspects of their lives, and facilitated to give their views at care plan review meeting. One young person said that *"although I would rather be at home but this is a good place, the staff members take my thoughts and opinions seriously"*. Another young person told inspectors that *"the nicest thing about the place is that the staff team really listen to you properly"*.

The young people were consulted about school and training courses. They were also involved in drawing up a daily menu and could choose their own clothes and were given a wide choice of leisure activities. The centre had a routine practice of making log books available for young people to read. The staff team were aware that children could read their own case files. However there was confusion amongst some of the staff team about aspects of the policy and refresher training in children's rights will help alleviate this. Inspectors recommend that staff receive further training in children's right to information held about them.

The centre had a well developed policy and procedure on complaints. The staff team interviewed were very clear on how to deal with them in a child friendly way that worked well especially on minor day to day issues. The young people told inspectors that if they made a complaint it would be taken seriously and resolved. There were three written complaints recorded at the time of inspection. Records indicate that they were notified to supervising social workers and dealt with in an appropriate and timely manner. The children's views of the outcome of their complaints were recorded in every case. This is good practice.

The staff team interviewed by inspectors and some of the young people said that they were aware of the organisation; the Irish Association of Young People in Care (IAYPIC), who are inter alia an advocacy group for children in care. However, they had not visited the centre at the time of inspection. Inspectors recommend that IAYPIC are invited to the centre to meet with young people.

Children's meetings had occurred in the recent past and where there was only one child in the centre, a one to one meeting still occurred prior to the staff team meetings.

Although there was very good information in the centre on a variety of religions and cultures and the young people were invited to a religious service of their choice once a week, there was no written policy on addressing the spiritual needs of young people as required by the regulations, Inspectors recommend that the centre develop written policy in relation to meeting the spiritual needs of young people.

#### *Monitoring*

The standard on monitoring was met in part. The centre had been visited by the monitoring officer on one occasion since the centre commenced in November 2009. She also had regular telephone contact. She met with the young people and staff and has requested the staff and management to complete a centre audit. The monitoring officer received notification of all significant events. She made herself available to the manager and staff mainly by phone for consultation as required. All the staff interviewed by inspectors found her supportive and her advice valuable. At the time of the inspection the monitor was in the process of completing a monitoring report. Inspectors recommend that SSI receive this report when it is completed.

#### *Social work and care planning*

The young people had social workers who visited them regularly and saw them privately in all cases. There was a good level of inter-professional work and interagency cooperation between the centre and social workers. Two social workers interviewed told inspectors that the centre team keep them well informed about all aspects of the young peoples care. Three of the young people interviewed said that they valued contact with their social worker and would talk to them if they had any worries. Social workers read case files from time to time as required by the standards. They felt the young people were safe in the centre. However, Inspectors were concerned to find in the recent past one very vulnerable young person had a succession of three supervising social workers contrary to best practice. At the time of inspection the young persons care plan did not meet with the requirements of the Child Care (placement of children in residential care) Regulations 1995. Although it was an emergency plan it had insufficient information and was undated and unsigned by relevant parties.

#### *Child safety and protection*

The staff team interviewed by inspectors had a good knowledge of centre policies and national guidelines on child safety and protection and were vigilant and clear about how they would act in the event of concerns about the safety of children. When different and difficult scenarios of a child safety nature were put to them they answered correctly with confidence and clarity.

There were three child protection concerns notified in relation to one young person since the commencement of the service. These concerns were about young people leaving the centre without permission and placing themselves at serious risk associating with adult known to the Gardai. Inspectors found that these were managed appropriately in accordance with *Children First: National Guidelines for the protection and Welfare of Children*.

However, inspectors were particularly concerned about one young person who was recently placed in the centre. The young person went missing four days after arriving in the centre. All professionals including the Gardai were notified in line with agreed protocols. However the young person not did not return for 10 days and had put themselves in serious physical danger and risk taking behaviour involving alcohol and narcotics, and mixing with adults known to the Gardai. Inspectors were told that there had been sightings of him/her during this period but this had not led to his immediate apprehension to a place of safety. Inspectors learnt that when the young person finally returned he/she was in a dishevelled and unhealthy state and was

brought to hospital. Inspectors recommend that this placement is reviewed as a matter of urgency. Inspectors recommend a comprehensive written review of all the circumstances surrounding this young person's case management to ensure there is learning from this extremely high risk event in order to inform future risk assessments practices and responses.

#### *Premises*

This standard was mostly met. The centre was located in an attractive six bed-roomed detached house surrounded by countryside, near a small town some miles from Dublin. It was a large Victorian house that was transferred from another part of the health service to children's services. It had recently been refurbished to a high standard. Serious efforts had been made to make it homely. However, because it is an old house that could be intimidating for children it is imperative that these efforts continue. The rooms were airy and attractive. Each young person had their own bedroom which they could personalise with pictures of their families and posters of their favourite bands. However, each of the children's bedrooms had a number on their bedroom door. Inspectors considered this institutionalised in appearance and recommend that it ceases and perhaps be replaced by the individual names of each child. The front and rear courtyards were untidy. Inspectors recommend that these matters are addressed immediately and steps are taken by management to ensure this environmental neglect does not recur.

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

All of the standards in this centre were either met or mostly met.

## 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 its purpose and function in relation to the age profile of young people on admission.

### 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 the acting deputy management post is regularised.
3. The HSE DML should ensure that formal staff supervision is provided to the staff on a regular and frequent basis in line with the centres policy.
4. The HSE DML should ensure that the centre manager receives regular, individual, formal supervision with her line manager as required by the standards and best practice.
5. The HSE DML should ensure that the Guardian Ad Litum receives notification of significant events as requested.
6. The HSE DML should ensure that there is a discreet section for education in the young peoples care file.

**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		√	

**Recommendations:**

7. The HSE DML should ensure that the monitoring officer provides, inter alia, an annual report as required by the standards.
8. The HSE DML should ensure that the SSI receive the monitoring officers self audit report when it is completed.

## 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	✓		

### Recommendations:

9. The HSE DML should ensure that the staff team receive refresher training on children's right to information about themselves.
10. The HSE DML should ensure that the Irish Association of Young People in Care are invited to the centre.

## 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:

11. The HSE DML should ensure that the placement of one young person referred to in the report is reviewed.
12. The HSE DML should ensure that all children in care have a comprehensive care plan as required by the *Child Care (Placement of Children in Residential Care) Regulations 1995*.
13. The HSE DML should ensure that young people have access to child psychology as required as a discrete service.
14. The HSE DML should ensure that the risk assessment tool used by the centre are reviewed a taking into account that comprehensive background information supplied to the centre is a crucial aspect of the assessment.

## 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		√	

### Recommendations:

15. The HSE DML should ensure that centre policy on spiritual needs of young people is further developed.
16. The HSE DML should review the number and frequency of children missing from care in the centre considering the risk found and responses undertaken so as to inform future policies and practices in the centre.

## 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		√	

17. The HSE DML should conduct a written review the circumstances surrounding the management of the unauthorised absence of one young person referred to in the report and issue the outcome report to the inspectorate.

## 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	√		

## 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	√		

## 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	√		

### Recommendation:

18. The HSE should ensure that the building is maintained appropriate to its purpose and function as a children's residential centre and specific actions referenced in the report are undertaken.

- 1.** The HSE DML should review its purpose and function in relation to the age profile of young people on admission.
- 2.** The HSE DML should ensure that the acting deputy management post is regularised.
- 3.** The HSE DML should ensure that formal staff supervision is provided to the staff on a regular and frequent basis in line with the centres policy.
- 4.** The HSE DML should ensure that the centre manager receives regular, individual, formal supervision with her line manager as required by the standards and best practice.
- 5.** The HSE DML should ensure that the Guardian Ad Litem receives notification of significant events as requested.
- 6.** The HSE DML should ensure that there is a discreet section for education in the young peoples care file.
- 7.** The HSE DML should ensure that the monitoring officer provides, inter alia, an annual report as required by the standards.
- 8.** The HSE DML should ensure that the SSI receive the monitoring officers self audit report when it is completed.
- 9.** The HSE DML should ensure that the staff team receive refresher training on children's right to information about themselves.
- 10.** The HSE DML should ensure that the Irish Association of Young People in Care are invited to the centre.
- 11.** The HSE DML should ensure that the placement of one young person referred to in the report is reviewed.
- 12.** The HSE DML should ensure that all children in care have a comprehensive care plan as required by the *Child Care (Placement of Children in Residential Care) Regulations 1995*.
- 13.** The HSE DML should ensure that young people have access to child psychology as required as a discrete service.
- 14.** The HSE DML should ensure that the risk assessment tool used by the centre are reviewed taking into account that comprehensive background information supplied to the centre is a crucial aspect of the assessment.
- 15.** The HSE DML should ensure that centre policy on spiritual needs of young people is further developed.
- 16.** The HSE DML should review the number and frequency of children missing from care in the centre considering the risk found and responses undertaken so as to inform future policies and practices in the centre.
- 17.** The HSE DML should conduct a written review the circumstances surrounding the management of the unauthorised absence of one young person referred to in the report and issue the outcome report to the inspectorate.
- 18.** The HSE should ensure that the building is maintained appropriate to its purpose and function as a children's residential centre and specific actions referenced in the report are undertaken.