



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**Social Services  
Inspectorate**

**A**

**CHILDREN'S RESIDENTIAL CENTRE**

**IN**

**HSE SOUTH**

***INSPECTION REPORT ID NUMBER: 416***

**Fieldwork Date: 14<sup>th</sup> September – 15<sup>th</sup> September 2010**

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**Centre ID Number: 73**

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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 centre in the Health Services Executive (HSE), South Area (SA) under Section 69 (2) of the Child Care Act 1991. Nuala Ward (lead inspector) and Orla Murphy (co inspector) carried out the inspection over a two day period between the 14<sup>th</sup> and 15<sup>th</sup> September 2010.

### **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, interviews with centre staff, relevant HSE personnel and managers, the monitoring officer and interviews with two young people, two parents, examination of relevant records and documentations detailed below and an inspection of the accommodation.

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

- The centre's statement of purpose and function
- The centre's policy and procedures
- Questionnaires completed by a young person
- Questionnaires completed by social workers
- The monitoring officer's reports
- The young people's care files
- Administrative files
- Details of physical restraints
- Details of unauthorised absences
- HSE Review report on the case management of young person that had previously resided in the service

### **1.2. Acknowledgements**

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

### **1.3. Management structure**

The centre had an acting centre manager who reported to the acting child care manager for the South Lee Local Health Area. This acting child care manager had responsibility for the HSE homeless residential services for children including the social work team for the service. He in turn reported to the general manager for South Lee Local Health Area.

#### 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*

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
# 1	17	Section 5 of the Child Care Act	4 days	0
# 2	17	Section 5 of the Child Care Act	3 weeks	0

## **2. Analysis of Findings**

The centre provided emergency placements of up to twelve weeks to adolescent boys (aged between 14 and 17 years of age) in need of accommodation as defined under Section 5 of the Child Care Act 1991. The service was based near the centre of a city and accepted referrals from the entire HSE South region. The centre was able to care for a maximum of five young people. Two young people were living there at the time of the inspection. The centre worked closely with a specialised social work team that worked with children out of home. This social work team was based in a separate building.

The centre had previously been inspected by SSI in 2004 and 2008. The inspection in 2008 found the majority of recommendations had been met and that the centre provided a good service to the young people. The findings of this inspection found a similar good standard of care by the staff team. The recommendations in this report relate to the standard of accommodation, some care practices and the admissions and discharges of children.

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

#### *Care of the young people*

The primary care of the young people was good. The young people and their parents spoke positively about the staff team. From interviews and the review of the records inspectors found the staff team were considered and reflective in their work. They had a good understanding of the needs of the young people and were able to identify areas for improvement in the wider services for young people out of home. They presented as committed professionals with a flexible approach in helping young people who were going through a time of crisis. Morale on the staff team was good. External professionals commented positively on the service provided by the centre especially its 24 hour availability to young people. Of note was that some young people referred themselves to the centre when they were looking for a place to stay. The staff team worked with the young people to establish their needs and made plans accordingly. Their health needs were met.

The staff team encouraged young people to attend their courses through monetary incentives and the no access to television or other distractions in the centre during the day. The food was good and meals were social affairs involving staff members, young people and sometimes their family members. There were activities for the young people at the weekend.

#### *Staffing and management*

The centre had undergone a change of management prior to the inspection. The previous manager that had been in place for a number of years was now the line manager and a new centre manager was appointed. These were temporary appointments originally for six months but were likely to continue for longer.

The change in management was viewed as positive by the staff team. The manager received regular supervision and support from the acting line manager who also visited the centre on a regular basis. The deputy manager actively supported the manager and staff team and worked evenings on a regular basis. The manager was not appropriately qualified and recently had commenced a course in health

management. The staff team told inspectors they were felt supported in their work by management.

The centre had a staff team of 14 but due to statutory leave at the time of inspection this was reduced to a staff team of ten. This had resulted in the use of agency staff members on a regular basis (16 shifts being covered by agency staff since July 2010). This was highlighted as a matter of concern for the acting manager and team and notified to senior management as a serious risk. There were no relief staff members. Inspectors noted that the same agency staff members were used as much as possible to minimise disruption and maintain consistency. This was good practice but a long term sustainable solution was required.

The centre records showed that training in the centre was ongoing and that staff had received training in Children First, Fire Safety, supervision and Therapeutic Crisis Intervention (TCI).

All members of the staff team had been appropriately vetted and were appropriately qualified. The centre had two regular cleaning staff that had not been vetted. This should be completed as soon as possible.

#### *Register*

This standard was met with all of the information required by regulations. Inspectors advise the centre to also record the address of the destination the young people were discharged to for future reference.

#### *Notification of significant events*

This standard was well met. The monitoring officer, parents, line manager and acting social work team leader told inspectors that there was good communication and sharing of information by the service. Written records of serious incidents were forwarded to the relevant persons in accordance with policy.

#### *Contact with families*

This standard was well met. The young people told inspectors that they saw and met with their families regularly. Two parents called into the centre during the inspection and spoke highly of the staff team members. The centre provided a welcome pack to parents about the service and encouraged parents to drop in if nearby, to attend meals and also kept in regular phone contact. Practice in this area was very good.

#### *Planning for children*

The staff team met with young people shortly after their admission and together devised a plan for their care. The social worker from the Out of Home Team was also involved in this process. There were regular planning meetings involving the children, the staff members, parents and social workers. Inspectors were told that the service worked well in moving children out of the service into other placements within the required 12 weeks. This was confirmed from the review of records. Inspectors noted that one of the young people did not have a plan as required by the centres' own policy.

### *After care and leaving care*

Care practices in after and leaving care was good in the centre. Considering the majority of young people accessing this service were older adolescents preparing for independent living was very important. The centre staff team encouraged young people in obtaining educational placements. They also assisted young people in cooking and other self-care skills. Some staff members highlighted the wish to provide more support to young people that leave the service. This should be examined by management to see if it is a needed service and if the centre has the capacity to provide it.

Inspectors noted that 9 of the 37 children (nearly 25%) had moved onto supported lodgings. These services were managed by the accommodation manager with the social work team for children Out of Home. Inspectors were told that these were viewed as positive placements for older adolescents that were assessed as requiring less support and were able live in semi-independent living.

One concern to inspectors was that one young person identified by the care team as requiring secure residential care was subsequently placed in supported lodgings. As supported lodgings provide a low support service this was a concern to inspectors. The HIQA had previously requested the HSE earlier this year to complete a national audit of supported lodgings to ensure providers had been vetted and assessed and that the services were being used appropriately. The HSE South should liaise with the HSE office of the National Director of Children and Families in examining their supported lodgings services as part of this national audit.

### *HSE Monitoring of centre*

This standard was met. The monitoring officer visited the centre on a monthly basis. Recommendations from these reports were implemented by the centre and he was notified of significant events.

### *Children rights*

This standard was met. The young people told inspectors that they know how to make a complaint and were provided with information about the service and their rights. They told inspectors they could raise concerns with staff members. The views of young people were sought through meetings and individual contact with key workers.

The young people were encouraged to access their daily logs but not their case files. The centre should ensure that young people are able to access their case files and any concerns regarding third party reports are managed appropriately. External professionals should be made aware that the centre operates an open document policy.

### *Absence without authority*

The national HSE policy on managing absences by the young people was in operation in the service. The local arrangement was that any young person absent from the centre was automatically considered high risk and responded to at that level by the Garda Síochána. When a young person did not return as expected the staff team attempted to contact them, encouraged them to return and contacted the Garda Síochána as required.

There had been 102 absences in the previous 12 months. These were generally for young people that were significantly late in returning home to centre in the evening and staff members were concerned. Fifty-one of these absences were by two young people. This is discussed further under the child protection section later in the report.

### *Education*

There was a good standard of education and both young people were enrolled in educational placements. This was commendable. The young people were actively encouraged by the staff team to attend their placements.

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

#### *Purpose and function*

Inspectors were told that that the centre provided a low support service in accordance with its purpose to care for young people primarily in need of accommodation. However, from the review of records inspectors noted that at times staff members were managing young people with very challenging and high risk behaviour including violence, criminal activity, serious mental health issues and drug use. The majority of young people were older adolescents aged 16 and 17 years. The service provided to these children was not low support but instead complex and challenging. Practices in managing these young people should be strengthened through specialised training for the staff team in these areas and a strong multi-disciplinary model of care involving mental health, hospital and addition services. Young people who are homeless should have priority access to these services. This multi-disciplinary model of care should be then reflected in the purpose and function.

#### *Admissions*

From the register inspectors found that there had been 42 young people admitted into the centre in the 12 months prior to the inspection. The majority of these children were placed in centre under Section 5 of the Child Care Act 1991. Therefore there were deemed as primarily in need of accommodation and were being cared for by the HSE. Two young people were in the care of the HSE under a voluntary care order.

There was an accommodation panel on a weekly basis involving the centre managers for local children's homeless services and the principal of the local social work team for children out of home. Inspectors were told that these meetings operated well and looked at referrals to the service. The centre management had developed a risk assessment process in assessing admissions to the service. This was good practice. However, inspectors were told that a lack of information from referring social workers hampered the effectiveness of this process. Considering boys as young as 14 could be placed in this service any risk assessment on admissions must be robust and any deficiencies to this process should be addressed.

#### *Discharges*

The centre did not have a policy for reviewing discharges of children from the centre. Inspectors were told that there had been no unplanned discharges from the centre in the previous year. However, from the review of four archived files inspectors found that two children had been discharged prior to the planned end of their placement due to safety concerns. One child was removed by the Garda Síochána and another child was discharged by staff members to home. Subsequently a professionals meeting was held to endorse the decision and therefore inspectors were informed

that these were not deemed as unplanned discharges. However, the experience for the young person was that their placement had ended unexpectedly.

Inspectors were told that another young person was moved abruptly to a new placement without appropriate planning between the professionals. The HSE monitoring officer was reviewing this placement due to concerns about communication between the professionals regarding the ending of this placement for the young person. Inspectors recommend the subsequent report is issued to HSE senior management.

Any discharge which occurs in contravention of the plan for the child is an unplanned discharge. An untoward incident or event generally triggers such discharges. The centre should devise a policy for the review of these discharges. The experience of the young person should be included in any such review.

#### *Discharging young people to bed and breakfast accommodation*

Of particular concern to inspectors was the option to discharge children to bed and breakfast accommodation. Inspectors were told that although no young person had been discharged into a bed and breakfast accommodation in the previous year it remained an option in an emergency if a young person's behaviour could not be safely managed. Inspectors were told that the local child care steering group had developed protocols in the safe use of bed and breakfast accommodation including notification to senior management and to the child protection system when a child is placed in such accommodation.

Placing vulnerable children unsupervised in bed and breakfast accommodation is unsafe. Inspectors were aware of two HSE case reviews on children that had died while in state care. These reports recommended that bed and breakfast accommodation should not be a part of a child's care experience regardless of their age or care status. The HSE nationally should issue a directive regarding this matter in accordance with the findings of these reports and best child care practice.

#### *Staffing roster and accessibility of service*

The centre was a 24 hour service with two staff members awake on duty each night. This availability of the service was viewed positively by the social work department in light of the often chaotic needs of the young people who are out of home.

There were two staff members on duty between 8am and 4pm, with a third on duty at 1.30pm from Monday to Friday. The manager or deputy manager is also on duty during this time. There were two staff members between 4pm and 9pm before two waking night staff members came on duty.

However, at weekends when the children have no school or courses to attend during the day and are more likely to be in the centre, only two staff members were on duty between 9am and 9 pm. Inspectors were told that the centre manager regular works on Saturdays.

The centre manager should examine the effectiveness of the current rota in meeting the needs of the young people especially at weekends. The young people told inspectors that at times there was very little to do in the centre and it could be very boring. The staff team should address this issue with the young people and identify any resources needed.

### *Supervision of staff members*

Formal supervision of staff members did not occur on a regular basis. The centre manager should provide supervision to the deputy manager and monitor that supervision is occurring.

### *Social Work Role*

The centre worked closely with the Out of Home social work team and both teams spoke well of the role of the other. Social workers and staff members worked with the young people and their families with a focus on returning young people home or other suitable placements as soon as possible. Social workers openly shared their case files with staff members. There was a partnership approach in working together to meet the needs of the young person. This was commendable.

Inspectors examined four archived files of young people that had accessed this service under Section 5 of Child Care Act 1991. Of these, three of the young people had significant needs including serious mental health issues and drug and substance misuse. It was not clear from the files how these young people were assessed by the social worker to see if a care order was required rather than being categorised as young people in need of accommodation. The HSE should ensure there is a robust social work assessment to ensure that young people have the appropriate care status if required.

Inspectors were told that young people in the care of the HSE were at times placed in the service. From the register inspectors noted 2 young people under voluntary care orders had been placed in the centre in the previous 12 months. There was a lack of clarity both in the centre policies and from interviews about how these placements differ from young people placed in the service under Section 5. A child in the care of the HSE accessing a homeless service is a serious matter of concern and should be dealt with as such. The centre management should ensure a strong gate keeping role in accepting such admissions. The policy document should reflect the statutory requirements for children in care and should be reflected in the centre and social worker's practice.

### *Care files for the young people*

There was inadequate information on file about the young people. It was not clear if the staff team or social workers in the Out of Home team had responsibility for obtaining information on any new young person self-presenting.

There are specific risks to be managed in the centre. Considering the transitory nature of the young people, and the challenges in supervising the young people due to the physical lay out of the building, gathering all available information from the child, their family and other agencies is extremely important. The responsibility for this information gathering should be clearly defined and understood for the safety of the young people.

### *Managing challenging behaviour*

The staff members relied on a relationship based approach to managing difficult behaviour. At times the staff team had to manage very serious and dangerous situations. Supervision of the young people was challenging as the accommodation was not fit for purpose with narrow corridors, multiple doors and no outdoor space. The staff team highlighted the need to balance the supervision of the young people while permitting them time alone. The supervision of the young people in this type of

service is extremely important as staff members can often have very little information about their background.

Sanctions were rarely used and young people told inspectors that the rules were fair. However, the young people may not receive any pocket money if they refused to get up before 10am or do no chores. This practice should be re-examined so a minimum amount of pocket money is protected. Inspectors were concerned that some young people stayed awake until 1 or 2 am at night. Inspectors were told that the staff team were constantly trying to address this but struggled at times.

All staff members were trained in Therapeutic Crisis Intervention model for managing difficult behaviour. The centre adhered to a no restraint policy due to specific concerns about the physical lay out of the building and the young people accessing the service. Inspectors were told that staff members would physically intervene if a young person was at risk if required and this was reflected in the centre policy. However, inspectors were not confident that the overarching duty of care to protect young people was understood by all staff members and that physical interventions should be reviewed in the same manner as physical restraints.

There had been 11 serious incidents in 2009. The nature of these incidents ranged from violence between the young people and towards staff members, serious damage to property and suicidal attempts by the young people. Inspectors noted two incidences whereby another young person physically intervened to separate two young people in altercation. The Garda Síochána were contacted to assist in managing four of these incidences. Inspectors noted that none of incidences had been notified to the HSE regional serious incident review group. This should be addressed immediately.

#### *Child Protection and safeguarding*

The staff team had a good understanding of safeguarding practices. There was a clear understanding of the need to challenge each other's practice as appropriate and report concerns to management. Practice in this area was good.

The centre had appropriately notified two concerns through the child protection notification system in the previous 12 months. These were dealt with by the relevant social work teams.

Inspectors noted that young people at serious risk to themselves either through suicidal ideation, substance misuse or repeatedly being absent from the centre and at high risk were not notified through the child protection notification system in accordance with *Children First: National Guidelines for the Protection and Welfare of Children*. The centre had recently introduced a risk register for notification of serious concerns to the local health manager. While this was commendable, it should occur alongside notification to the child protection system. As these young people oftentimes have multiple agencies involved in their case, inter-agency information sharing and communication is extremely important.

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

### *Accommodation*

The inspection in 2004 and again in 2008 highlighted concerns about the suitability of the premises for its purpose. The same concerns are repeated in the findings of this report. The service was based in an old building with a warren of rooms and narrow corridors with multiple doors. Inspectors would have serious concerns about the ability of the staff team to supervise a group of young people in this building. There was no front or back gardens. There was small cramped entrance hall and the front door opened directly onto the street.

As a matter of urgency this service needs to be relocated.

Pending this move the centre manager with the staff team should review the current layout of the service. There were three offices for staff members but no sitting room for the young people in the main building. One office was for the unit manager and personnel files were stored there. One of the other offices had a sofa and inspectors were told it was occasionally used as a visitor's room and a private area for staff members to talk with young people. The dining room was the only area in the main building that staff members and young people could sit together. There was a large recreational room to the rear of the building that was separate to the main building. This had board games, books, a pool table and television and a number of sofas.

The last health and safety check was 12 months previously. Fire drills had not occurred on a regular basis during the year. This deficit had been identified by the HSE monitoring officer. Inspectors were told that the designated fire officer in the centre was examining best practice in this area with due regard to the nature of the service. Considering the physical lay out of the building and high turnover of young people accessing this service, fire safety practices should be a priority.

The building required redecoration. The bathroom for the young people had broken tiles, no towel rack and was shabby. There were holes in some walls. There was a dead rodent in the wasteland at the back of the building and while access to this area was restricted it was still a health and safety concern. There were three large notice boards in the dining room and eight different notices in the kitchen. This created a somewhat institutionalised feel. Notwithstanding the nature of the service, adequate funding should be provided to the centre manager and staff team to make repairs and decorate the building.

## 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		√	

#### Recommendations:

1. The purpose and function should reflect the high level of support provided by the centre to some young people presenting with complex and difficult needs.
2. The HSE South should strengthen inter-agency co-operation for young people out of home including mental health, emergency departments in hospitals and addiction services.

### 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:**

3. The HSE should ensure that formal supervision occurs on a regular basis in accordance with centre policy.
4. The HSE should ensure that staff members receive specialised training in managing young people with substance misuse and with mental health issues.
5. The HSE should review the current rostering of staff members to ensure it is effective in meeting the needs of young people at weekends.
6. The HSE should ensure that all auxiliary staff that regularly work in the centre have the appropriate clearances from the Garda Síochána.

**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:**

7. The HSE South should ensure that all staff are aware of the rights of young people to read their care files and practice in managing these files supports this.

## 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:

8. The HSE South should develop a policy to review any placements of a young person which ends abruptly.
9. The HSE South should ensure the needs of the young people are assessed and the legal status of the young person is formalised when required.
10. The HSE South should liaise with the HSE nationally in the audit of supported lodgings to ensure local supported lodgings are being used appropriately.

## 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	√		
Discharges		√	
Children's case and care records		√	

### Recommendations:

11. The HSE monitoring officer should examine the number of young people whose placements had ended abruptly in the previous 12 months, the care practices surrounding such events and identify any areas for improvement.
12. The HSE South should put in place a system for reviewing unplanned discharges of young people from the service.
13. The HSE nationally should immediately issue a directive to local health areas on the use of bed and breakfast accommodation for children being cared for or who are in the statutory care of the HSE
14. The HSE South should ensure that the system for gathering information about young people accessing the centre is robust and stored on file and that care records contain all relevant information.

15. The HSE South should identify the type of serious incidents that should be forwarded to the HSE South Serious Incident Review team.

## 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:

16. The HSE South should ensure that concerns about the safety of young people are notified through the child protection notification system in accordance with *Children First; National Guidelines for the Welfare and Protection of Children*.

## 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	√		

## 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:

17. The HSE South should provide a more suitable premises for the service as previously recommended in the HIQA inspection in 2004 and again in 2008.
18. The HSE South should carry out a health and safety audit, make the necessary repairs and redecorate the building.

#### **4. Summary of recommendations**

- 1.** The purpose and function should reflect the high level of support provided by the centre to some young people presenting with complex and difficult needs.
- 2.** The HSE South should strengthen inter-agency co-operation for young people out of home including mental health, emergency departments in hospitals and addiction services.
- 3.** The HSE should ensure that formal supervision occurs on a regular basis in accordance with centre policy.
- 4.** The HSE should ensure that staff members receive specialised training in managing young people with substance misuse and with mental health issues.
- 5.** The HSE should review the current rostering of staff members to ensure it is effective in meeting the needs of young people at weekends.
- 6.** The HSE should ensure that all auxiliary staff that regularly work in the centre have the appropriate clearances from the Garda Síochána.
- 7.** The HSE South should ensure that all staff are aware of the rights of young people to read their care files and practice in managing these files supports this.
- 8.** The HSE South should develop a policy to review any placements of a young person which ends abruptly.
- 9.** The HSE South should ensure the needs of the young people are assessed and the legal status of the young person is formalised when required.
- 10.** The HSE South should liaise with the HSE nationally in the audit of supported lodgings to ensure local supported lodgings are being used appropriately.
- 11.** The HSE monitoring officer should examine the number of young people whose placements had ended abruptly in the previous 12 months, the care practices surrounding such events and identify any areas for improvement.
- 12.** The HSE South should put in place a system for reviewing unplanned discharges of young people from the service.
- 13.** The HSE nationally should immediately issue a directive to local health areas on the use of bed and breakfast accommodation for children being cared for or who are in the statutory care of the HSE
- 14.** The HSE South should ensure that the system for gathering information about young people accessing the centre is robust and stored on file and that care records contain all relevant information.
- 15.** The HSE South should identify the type of serious incidents that should be forwarded to the HSE South Serious Incident Review team.

- 16.** The HSE South should ensure that concerns about the safety of young people are notified through the child protection notification system in accordance with *Children First; National Guidelines for the Welfare and Protection of Children*.
- 17.** The HSE South should provide a more suitable premises for the service as previously recommended in the HIQA inspection in 2004 and again in 2008.
- 18.** The HSE South should carry out a health and safety audit, make the necessary repairs and redecorate the building.