



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**A**

**CHILDREN'S RESIDENTIAL CENTRE  
IN THE  
HSE WESTERN AREA**

***INSPECTION REPORT ID NUMBER: 430***

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## **1. Introduction**

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Services Executive (HSE) Western Area (WA) under Section 69 (2) of the Child Care Act 1991. Orla Murphy (lead inspector) and Sharron Austin (co-inspector) carried out the inspection on the 12<sup>th</sup> and 13<sup>th</sup> of January 2011. The centre had relocated from the city centre to a more rural location in the wider geographical area since the previous inspection in 2009.

### **1.1 Methodology**

The judgements of inspectors are based on an analysis of findings verified from more than one source of evidence gathered through observation of practice, interviews with relevant HSE staff members and managers, interviews with young people, an examination of records and documentation and an inspection of accommodation.

The following are some of the centre documents available to inspectors during this inspection:

- statement of purpose and function
- policies and procedures
- young people's care plans and care files
- census forms on management and staff
- young people census forms
- 4 questionnaires completed by social workers
- administrative records
- guides for young people
- HSE monitoring officer report
- previous inspection report and follow-up report
- questionnaires completed by young people
- supervision records
- staff rotas
- safety statement
- an internal review of the service
- records of complaints

During the course of this inspection, inspectors interviewed the following people:

- social care leader
- regional residential child care manager
- two social workers
- four social care workers
- HSE monitoring officer
- senior psychologist attached to the service
- three young people

### **1.2 Acknowledgements**

Inspectors wish to acknowledge the assistance and cooperation of the young people, staff members and other professionals who participated in this inspection.

### 1.3 Management structure

The acting manager of the centre had left her post in the month prior to the inspection. The centre was managed by a child care leader and the external management structure consisted of a regional manager for child care who reported to the acting child care manager. They reported to the general manager who in turn reported to the local health manager for the area.

A new acting centre manager was due to commence in post soon after the inspection took place.

### 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 years 8 months	(*) No care order	5 months	3 foster care
# 2	17 years 1 month	(*) No care order	4 months	1 residential 1 supported lodgings
# 3	17 years 5 months	Care order	4 weeks	2 foster care 1 residential care
# 4	13	Voluntary Care	3 weeks	1 foster care

**(\*) Placements were under Section 5 of the Child Care Act 1991.**

## 2. Summary of Findings

The centre had previously been inspected by SSI in 2009 and all of the recommendations arising from that inspection were met.

The centre was an emergency and medium term children's residential centre providing accommodation for homeless boys between the ages of 15 and 17 but had recently changed its statement of purpose and function to include the admission of girls and the admission of children less than 15 years in an emergency. It was located in a two storey detached building in a rural area. It had a capacity to accommodate four young people. Three of the placements were deemed medium term residential beds and the fourth an emergency bed.

The medium term placements were determined by the admissions panel for residential care. The young person in an emergency placement was able to remain in the centre for a period of 28 days and such placements were dealt with by the centre manager as the need presented. Some emergency placements progressed to being medium term placements after consideration by the admissions panel. The regional manager was informed of any emergencies. The centre provided a regional service to the HSE areas in counties Limerick, Clare and Tipperary North .

At the time of the inspection there were four young people in residence. Two were in their placements for 5 and 4 months respectively, and two young people had begun their placement in December 2010. The centre had 11 admissions in the 12 months prior to the inspection. Admissions to the centre ceased for four weeks in August 2010 following the discharge of a young person who was involved in a serious incident outside of the centre. This incident had occurred following a period of difficulty within the unit where the management of behaviour of the young people was not effective and some incidents had escalated to an unsafe level.

Senior managers and the staff team took this opportunity to regroup and to reflect on the incidents within the unit. Staff worked with the psychologist and external consultant attached to the centre and analysed their responses to specific behaviours and incidents, to gain a greater understanding of the behaviours and how they could be managed differently in the future. This is discussed further in *Management and Staffing and Management of behaviour*.

The centre operated a Trauma model of Care which considers the young person's history, the environment, relationships and specific techniques to assist the staff in exploring behaviour and helping young people with the challenges they face.

At the time of the previous inspection in 2009, there were concerns about some young people's involvement in feuding between families in the city and the associated violence with this. The previous location of the service, in a city centre, became increasingly unsuitable. Staff reported difficulties from young people's negative behaviour impacting on passers by and both staff and young people felt at risk from associates of some young people, including receiving threats and property damage. It was decided to relocate the service to another property owned by the HSE which was in a rural location. The service moved to the current location in late 2010.

Inspectors found the centre had gone through a significant period of crisis and change, which resulted in improved risk management strategies and a more confident and cohesive team. The team managed well to respond to the needs of the young people who were resident at the time of the inspection. The provision of primary care was good and in operating with a new model of care the staff felt more empowered to support young people whose behaviour challenged the service. Relationships between staff and external management had improved through the service review process and all conceded that while the last year had been difficult, the outcomes for the team and young people were much more positive.

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

#### *Management*

The acting centre manager elected to take a redundancy package three weeks prior to the inspection. Her departure was swift as the nature of the package was based upon a limited time frame to accept the redundancy. A social care leader stepped into the management role until a more permanent solution could be arranged. She reported to the regional residential child care manager, who was line managed by the local health management (the structure of which had changed at the time of the inspection). The previous acting manager had been in post for three years at the time of her departure which had provided a stable management presence within the unit. The current social care leader had been in post for over 4 years and also provided stability for the team during this time. Inspectors acknowledge that the social care leader had provided effective leadership for staff and young people in recent weeks. A new acting manager had been identified and was due to commence in post shortly after the inspection. This manager was known to staff as she had managed the unit some years previously, and the regional residential child care manager and staff were confident that the unit would continue to be managed effectively.

The regional manager had conducted a review of the service in 2010 and a copy of this review was provided to inspectors. The review was extensive and involved staff, parents, young people, social workers and other stakeholders, identifying the strengths and weaknesses of the service. Staff acknowledged while it was a difficult process to go through at times, it was very useful to reflect on the service and felt it had helped them to identify improvements that were needed and to put these in place.

#### *Register*

The centre had a register in place. It contained the name of the young person, date of birth, legal status, social workers names and contact details. It also contained details of parents of young people and the reason for the admission and dates of discharge. The register contained the details of the follow-on placement for young people. Inspectors advised that the location of archived files of young people who have left the service be noted on the register, but found the information contained in the register met the required standard.

#### *Notification of significant events*

The centre had a policy on reporting significant event including: absconding, assault, threats, physical intervention, sexualised behaviour, self harm, disruptive behaviour, damage to property, child protection concerns and drug, alcohol and solvent misuse.

These reports were individually numbered for tracking purposes and included details on the young person, staff involved, precipitating factors, details of the event, action taken by staff and action taken by social worker. These forms were sent to the social worker, monitoring officer, regional residential child care manager and the therapeutic crisis intervention monitoring and review committee. The monitor and social workers interviewed by Inspectors were satisfied that they were notified promptly of all significant incidents that occurred.

### *Staffing*

Inspectors were provided with details on the staff working in the centre. There were 18 care staff assigned to the centre covering 16 whole-time equivalent positions. There were three social care leaders, but two have been on leave for a significant period of time. The remaining social care leader was managing the unit and covering all social care leader duties. Inspectors found that formal supervision was regular and up to date despite the absence of the other post holders and she had provided effective leadership and continuity to the team which was commendable.

The roster showed that care staff worked ten or twelve hour shifts and staff covered both day and night shifts. Inspectors found that most staff had worked in the centre for a long time and the average length of time in post was over five years. There was two agency staff working in the unit on a full time basis, covering staff leave. Inspectors were informed that these staff had received an induction and training, as any permanent staff member would receive. Inspectors were satisfied that all staff, including agency staff, had garda vetting and all references were in order. All staff were suitably qualified in health and/or social care.

### *Training and development*

Centre staff had participated in training in therapeutic crisis intervention, supervision, understanding self harm, misuse of drugs and alcohol, child protection, first aid and risk assessment since the last inspection. All staff had attended training on the new model of care in the centre, the Trauma model. Inspectors were informed that further training in risk assessment and analysis is planned to be held in February 2011.

### *Monitoring*

Following two visits to the centre, one monitoring report was issued by the HSE monitoring officer. The visits incorporated meetings with the young people, the care staff and the acting centre manager. Documentation in the centre was also reviewed. The report issued concentrated on the placement of one young person who was involved in a serious incident outside the centre in 2010, examining significant events, the management of behaviour and challenges that the service faced during this time.

The HSE monitor informed inspectors that she was satisfied that although the centre had experienced a difficult year previously; the staff team had worked extremely well in the review of the service and were committed to the young people in the centre.

### *Suitable placement and admissions*

The placement of young people in the centre on an emergency basis was primarily governed by the Child Care Act 1991, Section 5. Where it appeared to the HSE that a child in its area was homeless and following an enquiry into the child's circumstances and verification that there was no other accommodation available to the child, the

HSE could "take such steps as are reasonable to make available suitable accommodation for him". The centre categorised these admissions as "Section 5 admissions".

The HSEWA had a protocol in place for young people admitted under Section 5 of the Child Care Act 1991. This protocol outlined the commitment to assessment and support planning for young people admitted under Section 5; however the basis of Section 5 is that a young person needs accommodation only. Inspectors are of the opinion that both care and accommodation is provided to these young people and the Authority is currently addressing this anomaly with the HSE nationally to identify if the use of Section 5 is appropriate in these circumstances.

Two of the young people had been placed in the centre under Section 5 of the Child Care Act 1991. The remaining two young people were subject to care orders. The young people on Section 5 placements both had support plans regarding their placement and future which were found to be of good quality. Support planning meetings were held regularly for both young people.

Inspectors met with three social workers and while there was full agreement that all of the young people were appropriately placed at that time, it was conceded that as one young person was significantly younger than the other young people resident in the centre, the placement was not ideal but necessary as the admission had been an emergency. This young person was to move onto a high support placement soon after the inspection. Staff also expressed some concern about the dynamic in the group in light of this placement and Inspectors advised that in such cases placements are subject to increased review and vigilance. Inspectors found good quality information available on file for all of the young people in the centre and also found very detailed initial assessments and social histories on file.

One young person had spent only three nights in the centre since their admission in December 2010, and was missing in care at the time of the inspection. This young person had maintained daily telephone contact with staff and the issue was subject to meetings with Gardai under the HSE's *Missing in Care* protocol. Staff maintained regular contact with Gardai and Inspectors were satisfied that the staff team were making every effort to encourage this young person to return to the unit. Inspectors have since been informed that this young person had been returned to the centre by Gardai.

#### *Contact with families*

Young people who presented to the centre as homeless had, on many occasions, experienced conflict within their families resulting in relationships breaking down. The centre had a pivotal role in facilitating young people and their families opening communication channels, re-establishing contact and rebuilding relationships where possible. Inspectors were informed that family were encouraged to visit the centre and one parent and godparent visited on the first day of the inspection. The centre maintained records of all contact with families and these demonstrated that contact was regular.

#### *Administrative files*

Inspectors found that all relevant records were in place and used appropriately by the staff team. The content and organisation of care files, log books and other records was of a good standard.

### *Supervision and visiting of young people*

As indicated previously in the report, all four young people in the centre had a named social worker. All three young people interviewed informed inspectors that they had a good relationship with their social workers. One young person described her social worker as "lovely". All three young people said their social workers visited regularly and were contactable by telephone.

One social worker was assigned to the two young people on Section 5 placements. She was only allocated to the Youth Homelessness department for two days per week and found the limited time available challenging, but the young people and staff felt this social worker visited frequently and was responsive to them when contacted. All social workers signed care files to indicate that they read the young people's files regularly. Records of visits were maintained in the centre of social worker visits.

### *Social Work Role*

Two of the young people were not in the care of the HSE and did not have statutory care plans or statutory care plan reviews, but did have full assessments and support plans on file. The remaining two young people both had full assessments and statutory care plans on file. Both of these young people had been admitted to the centre in December 2010 and their initial reviews were due to take place. Inspectors found that the social work role was fulfilled by all social workers and both staff and social workers that spoke to inspectors were satisfied with the communication between the centre and the social work department. Social workers told inspectors they were kept informed by the centre staff of all significant events including absences.

### *Children's case and care files*

Inspectors found that care files were well structured, robust and held all of the required documents. Files were of a high standard and the HSEWA had produced a booklet to guide young people through their rights in relation to reading the information in their files. The files of young people discharged from the centre were stored in one central archiving location. Inspectors advised that this location is recorded in the register for each recorded discharge to assist any young person seeking their files in the future.

### *Emotional and specialist support*

The centre had adopted the Trauma model of care which was being used in other centres in the region. Inspectors found that a high standard of emotional and specialist work was being carried out and this yielded positive outcomes for young people in the management of behaviour, improved relationships with staff and families and the young people's understanding of their past experiences and future aspirations.

The centre had a psychologist who worked with individual young people and the team providing support and guidance in relation to the care of young people and the management of behaviour. The psychologist also facilitated community meetings which involved young people and staff. One inspector attended a community meeting on the first evening of the inspection and found this forum to be an excellent venue for staff and young people to discuss issues and resolve any

concerns as a group. The meeting was observed to be inclusive and productive for all who attended.

Both staff and young people informed inspectors that the input from the psychologist was very beneficial and they felt supported by him. The psychologist informed inspectors that the staff team were enthusiastic and committed to working with the Trauma model and this has yielded positive outcomes for young people. Inspectors observed staff to be relaxed and confident when interacting with young people and young people could identify staff that they would share their problems or concerns with.

#### *Preparation for leaving care*

Most young people who left the centre in the 12 months preceding the inspection returned home with supports or moved onto supported lodgings. Two young people who would be leaving care in the next 12 months were being prepared by the staff team to be more independent. Each young person was moving at their own pace but both had evidence on file of skills assessment and development in areas such as self care, household tasks, occupation and finance. One young person had developed these skills to a high standard and was becoming increasingly independent. This young person informed inspectors that centre staff and his aftercare worker had been very supportive in his transition towards leaving care. He found the advice he received invaluable and was confident about his future and his ability to live independently.

#### *Individual care in group living*

The centre was initially developed as an accommodation for homeless young people where they accessed the service in the evening. The centre had then evolved to providing full time residential care. Routines have developed where young people attend education, training or places of employment. It was evident throughout the inspection that staff were fully aware of individual young people's strengths and needs and young people were observed being comfortable in their home and in interactions with staff. Inspectors observed good relationships between the young people themselves and with staff. There was positive banter between staff and young people throughout the inspection, in addition to any stress or concern being dealt with sensitively by the staff. Staff also showed good authority with young people and diffused any incidents quickly.

Young people raised concern that their monthly clothing allowance had been "stopped" due to "cutbacks". They also raised concerns about potential reductions in their pocket monies. Inspectors raised this with the senior external manager of the service and were informed that the service has just completed a review of all financial expenditure such as pocket money, chore money and clothing allowance. Inspectors were informed this was to ensure that funding provided is realistic and reflect the reduction in costs of items such as clothing. Inspectors were advised that clothing will now be purchased on an "as needed" request basis with clothes also being purchased for special occasions (such as birthdays and Christmas). However, two young people informed inspectors they didn't feel that requests for clothes would be agreed. Inspectors advise that the centre keeps a record of requests by young people for clothing and any subsequent purchases or refusals to demonstrate the equity and effectiveness of the new system.

One young person had developed an interest in keeping poultry at the centre and had been encouraged to develop this responsibility. He had managed this extremely well, being accountable for the care of the poultry, and both he and staff were proud of his achievements.

### *Managing behaviour*

The centre had a written policy for responding to inappropriate behaviour. Therapeutic Crisis Intervention (TCI) was identified by centre staff as the intervention used by care staff to deescalate situations.

In 2010, the centre experienced serious challenges in managing two young people who had very complex needs and presented the team with very challenging behaviour. There were 118 significant incidents in 2010, 49 of which were in the months of May and June. There were assaults on staff and serious threats to staff. Young people were absent at risk and misusing drugs and alcohol. When they returned to the centre under the influence of these substances, situations escalated. Gardai were called upon frequently to deal with young people who became threatening and/or violent. Staff were increasingly fearful and young people felt able to engage in intimidating behaviour. Some staff had to go on leave due to stress and/ or assaults and the staff team had little or no authority with these young people. Staff informed inspectors that this was a very difficult period for them and for the young people.

This reached crisis point when one young person was involved in a serious assault outside of the centre and was immediately arrested and detained. This incident had a profound effect on the team and a decision was made by managers to halt any admissions to the centre. During this time the staff team received support and counselling. The team met frequently with the external consultant, the senior psychologist for residential care in the region and senior managers to reflect on the tumultuous period and to look at how incidents and behaviours had affected the team and young people. The team put a lot of effort into introducing a new model of care and developing a more confident authority and response to challenging behaviour.

During this inspection inspectors observed that staff presented as much more confident and relaxed with young people and staff informed inspectors that their confidence and skills had improved significantly with the new model of care and reflections on previous incidents.

### *Consultation*

Young people confirmed they had been consulted about their wishes upon admission to the centre. They were given information about the centre and the expectations in relation to house rules and behaviour. As described previously, weekly community meetings were held where young people and staff discussed issues and resolved any concerns. The inspector who attended the community meeting on the first evening of the inspection observed staff and young people voicing their ideas and opinions, and felt it was a productive forum for both. Young people also confirmed they attended care planning or support planning meetings. All three young people that spoke to inspectors stated they felt their opinion was valued by staff, and while they felt some rules were too strict (such as times mobile phones should be used); they understood why these rules were in place.

### *Complaints*

Inspectors examined the record of complaints in the centre and found there were 8 complaints by young people in the year preceding the inspection. These related to issues with rules and group living and where possible, all were resolved appropriately to the young persons satisfaction. One complaint was made by a person external to the centre and this is still under investigation. The young people that spoke to inspectors were clear about the complaints process and all identified the social care leader as the person they would raise concerns with initially.

### *Restraint*

The social care leader reported that there were no physical restraints or single separations in the centre over the past twelve months. Records indicate there were three physical interventions in the same time period. Physical interventions can consist of blocking young people's movements or standing between young people if staff feel a situation is escalating.

### *Absence without authority*

On the first day of the inspection, inspectors were informed that a young person who was over 17 years old was absent for the previous two weeks. This young person was admitted to the centre in December 2010 and had only spent three nights in the centre since his admission. The young person had a history of refusing to engage with the HSEWA. The young person was reportedly unhappy with the rural location of the centre. Staff were in daily telephone contact with the young person and gardai were looking for him to return him safely. He refused to disclose his whereabouts to staff, but gardai were satisfied that he was at least maintaining contact. A meeting with gardai and staff was held on the first day of the inspection. This meeting was part of a series of meetings that are held when young people in care are missing as part of the *Missing in Care* protocol that was developed between the HSE and the Garda Siochana nationally to address the issue of absconsions from residential units. Inspectors have been advised that this young person was returned to the centre two weeks after the inspection.

Records indicated there were 42 absences involving five young people in the year preceding the inspection. A significant proportion of these (75%) related to two individual young people who had been discharged from the centre in 2010. These absences ranged from 30 minutes to 23 hours and were largely around the time that the centre was experiencing difficulties managing the behaviour of these young people.

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

### *Statutory care plans*

Two young people were in the care of the HSEWA and the remaining two young people were placed in the centre under Section 5 of the Child Care Act 1991. Both the relevant care order documents were on the relevant young people's files. Both young people who were in the care of the HSEWA had up to date statutory care plans which were found to be comprehensive. Both these young people had only been resident in the centre since December 2010, so no statutory reviews had yet taken place. As stated previously the young people on Section 5 placements both had support plans regarding their placement and future which were found to be of good quality. Support planning meetings were held regularly for both young people. In addition, placement meetings were held every two weeks for all young people and these were attended by social workers and keyworkers. Staff and social workers all stated that these meetings were very useful and informative, identifying the strengths and any concerns in the placement at an early stage.

There remains an issue regarding the placement of young people under Section 5. Young people are being provided with care and accommodation, yet Section 5 only addresses accommodation needs. The previous SSI inspection in February 2009 noted:

*"Inspectors formed the view that the admission of a young person to the centre under Section 5 of the 1991 Child Care Act was initially to address the issue of homelessness. As outlined in the Youth Homeless Strategy 2001, Department of Health and Children, Objective 6 "A comprehensive assessment of children who become homeless will be carried out as the basis for individual action/care plans for case management/key working with the young person where necessary."*

Inspectors hold the view that the outcome of an assessment should determine whether a young person presents with care needs. It would not be sufficient for the HSE to accommodate a young person in a care facility under Section 5 if care needs are identified. The Authority has sought clarification from the HSE National Children and Family Services office regarding the anomaly in the provision of accommodation versus the provision of accommodation and care and as such, the standard in this regard remains partly met. However, Inspectors acknowledge that the protocol and support planning system introduced by the HSEWA is of a good standard.

### *Aftercare*

Inspectors were told the HSEWA operated an aftercare service. One young person was engaged with an aftercare worker but neither young person who was 17 years had an after care plan. Inspectors recommend that given the age of these young people, aftercare plans are developed for both as a matter of urgency. The young person who was absent from the centre had a care plan but did not have an aftercare plan. Inspectors were informed that this young person had an allocated aftercare worker but persistently refused to engage with any services. Inspectors recommend efforts are made to develop a plan with this young person.

### *Health*

This standard was mostly met. All the young people had access to a G.P. and dental services. Staff had a good awareness of the health needs of the young people. Records of appointments were maintained. Medical assessments on admission to

care were carried out in all cases. Inspectors found medical histories were in place on care files. In the absence of some documentation, inspectors found evidence that efforts were made to obtain the information. One young person needed extensive dental treatment and staff were supporting them through this.

Two of the young people smoked and one of these young people was under 16. Young people smoked at the front and side entrance to the centre. Inspectors did not find any incentive or cessation programmes in place to discourage smoking and recommend staff actively explore such programmes for young people and make these available to them.

#### *Education*

This standard was mostly met. Inspectors found a culture in the centre that promoted education and training. Young people were encouraged to engage with local services and schools. There was access to the local youth services and one young person had completed their junior certificate to a high standard within this youth service. One young person had secured a place at a school but had sporadic attendance. Teachers from the school had provided home tuition in the centre for this young person, but the young person found it difficult to engage with this at times due to complex emotional difficulties. At the time of the inspection this young person was not attending any educative program. The staff team were seeking different ways to address this and Inspectors recommend efforts are continued to support the young person to engage in an educative programme and attain further qualifications to support any future career or further study.

#### *Child protection*

Children First, National Guidelines for the Protection and Welfare of Children 1999 was the policy of the centre in responding to child protection. Staff were trained in Children First and it was seen as one of the core areas for ongoing training for staff. Inspectors noted child protection conference records on young people's files.

There were a range of comprehensive risk assessments carried out in relation to young people. Inspectors found child protection notifications on the file of one young person regarding this young person's siblings. Staff had made these notifications following disclosures made but staff had not been notified of the outcome of these. The Authority has written to the HSEWA to request this information and recommend that these outcomes are placed on the relevant file.

#### *Accommodation*

The centre was a spacious detached two storey property in a rural location. It was located behind electronic gates, set back from a busy road. It was a four bedroom facility with all bedrooms on the top floor. Inspectors found the general condition of the centre to be good. The centre had a large living room off the hallway and had a small external building that was used for private visitors or as a quiet space. There were sufficient toilet and shower facilities in the centre and the large kitchen/dining area was the area both staff and young people congregated. There was a conservatory attached to the kitchen area. The centre had a relaxed and homely atmosphere and young people were observed being very comfortable in their surroundings.

Young people informed inspectors that the rural location of the centre caused difficulties at times if they wanted to access shops/services or family and friends. The

centre had the use of a vehicle but as there were four young people resident, there was limited availability to get lifts if the vehicle was being used to transport one young person to a meeting or school. Young people said that because of this, they had to decide too far in advance if they wanted to visit someone or go to the shops. They felt they could not make spontaneous choices about activities or seeing friends that lived elsewhere. Staff conceded this was a difficulty. Inspectors recommend that senior managers assess and review transport provision, to determine if there is a need for a second vehicle or alternative transport for young people's activities and needs.

Inspectors noted that there were closed circuit television cameras (cctv) in some communal areas throughout the centre. These cameras were already in place prior to the service move to the home. Inspectors were informed the cameras were mostly used to monitor the outside of the premises but all cameras were in operation during the inspection. There were no notices advising young people or visitors that cctv was in operation in the centre and permission to store images was not sought, which does not comply with data protection legislation. Staff informed Inspectors at the time of the inspection that images from these cameras were stored indefinitely on a server external to the centre, however the external line manager of the service advised inspectors following the inspection that all images are recorded over after 28 days. Most staff that spoke to inspectors felt that the cameras offered them greater protection in the event of serious incidents such as assaults by young people. However, Inspectors formed the opinion that cameras merely record these events and do not provide any protection against incidents. Staff also cited a previous incident where a young person actively sought to threaten staff in areas of the centre where there was no camera. There are several complex issues that need to be considered relating to the use of cameras, such as the right to privacy for young people and visitors, the fact that the centre is home to four young people, data protection rights and the legal implications of these. The centre had two waking staff on duty at night who supervised young people. Inspectors are of the opinion that cameras in children's residential centres should not be used and as such, inspectors recommend the use of cctv inside the centre ceases.

### *Safety*

The centre had a corporate safety statement which provided a broad overview of safety requirements including a smoking policy and a fire prevention management policy. This document was signed by the regional residential child care manager. The social care leader advised inspectors that a health and safety audit had not been carried out since the service moved to its present location.

Inspectors recommend a health and safety audit of the premises is undertaken without delay.

### *Fire safety*

Inspectors undertook an inspection of the premises as part of the fieldwork. Documentation was provided to the inspectors which clarified that the fire alarm system was maintained and tested in 2010 by an external fire protection company. Training in the use of fire extinguishers was also provided to centre staff in 2010. Fire and safety checks were carried out regularly and specifically looked at fire doors, emergency lighting, fire detectors and fire escapes.

Inspectors were concerned that there was no alternative escape route from the first floor of the property should the stairway be inaccessible. Inspectors were provided

with copies of requests from the senior external manager of the service for a fire ladder to be installed in the office area as an added safety measure. This request has still not been addressed by the HSEWA and a fire ladder should be fitted as a matter of urgency.

Inspectors were provided with a fire safety report for the centre. It provided confirmation that all statutory requirements relating to fire safety and building control had been complied with as required under standard 10 with the condition that a fire resistant wall was put in place in the kitchen area. This wall has not been put in place and therefore Inspectors recommend the HSEWA satisfy itself that statutory requirements are complied with fully without delay.

***There were no practices that did not meet the required standard***

### 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	√		

#### 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	√		

### 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	√		

## 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	√		
Discharges	√		
Aftercare		√	

### Recommendations:

- 1. The HSE WA should ensure that the three identified young people in the centre have aftercare plans in place.**
- 2. THE HSE WA should seek clarification from the HSE nationally regarding the use of Section 5 of the Child Care Act 1991 to provide care and accommodation to young people.**

## 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	√		

## 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 the outcome to the child protection notification on one young person's file is sought and a copy retained on the file.

## 8. Education

### Standard

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

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

### Recommendation:

- The HSEWA should ensure that efforts are continued to engage the young person identified in an educative or training placement

## 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 ensure that incentive and cessation programmes are actively offered to young people to discourage 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:

- The HSE WA should ensure a review of the sufficiency of the current transport available to the service.
- The HSE WA should cease the use of closed circuit television cameras inside the centre.
- The HSE WA should install a fire escape ladder on the first floor of the centre as a matter of urgency.
- The HSE WA should ensure that all statutory requirements relating to fire safety and building control have been complied with and the relevant documents forwarded to the inspectorate once this is completed.

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

- 1.** The HSE WA should ensure that the three identified young people in the centre have aftercare plans in place.
- 2.** The HSE WA should seek clarification from the HSE nationally regarding the use of Section 5 of the Child Care Act 1991 to provide care and accommodation to young people.
- 3.** The HSE WA should ensure the outcome to the child protection notification on one young person's file is sought and a copy retained on the file.
- 4.** The HSEWA should ensure that efforts are continued to engage the young person identified in an educative or training placement.
- 5.** The HSE WA should ensure that incentive and cessation programmes are actively offered to young people to discourage smoking.
- 6.** The HSE WA should ensure a review of the sufficiency of the current transport available to the service.
- 7.** The HSE WA should cease the use of closed circuit television cameras inside the centre.
- 8.** The HSE WA should install a fire escape ladder on the first floor of the centre as a matter of urgency.
- 9.** The HSE WA should ensure that all statutory requirements relating to fire safety and building control have been complied with and the relevant documents forwarded to the inspectorate once this is completed.