



# Health Information and Quality Authority

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**A**

**HIGH SUPPORT CENTRE**

**IN THE**

**HSE WEST AREA**

***INSPECTION REPORT ID NUMBER: 449***

**Fieldwork Date: 26<sup>th</sup> - 27<sup>th</sup> January 2011**

**Publication Date: 29<sup>th</sup> March 2011.**

**SSI Inspection Period: 13**

**Centre ID Number: 190**

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## **1. Introduction**

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection under Section 69 (2) of the Child Care Act 1991 of a high support children's residential centre in the Health Services Executive West Area (HSEWA). Orla Murphy (lead inspector) and Nuala Ward (co-inspector) conducted the inspection over a two day period from the 26<sup>th</sup> to the 27<sup>th</sup> of January 2011.

The centre was located in a large detached dormer style house with extensive grounds in a rural setting. The centre had been under the aegis of a religious order up to 2003 when it was transferred to the then Mid Western Health Board now the Health Service Executive West Area (HSEWA). Its' statement of purpose and function stated it was designated as a short term high support facility for five children/young people aged between 10 – 17 years of age. At the time of inspection there were three girls living in the centre. A fourth young person had been living in a more secure placement for a period of time and was due to begin a transition back to the centre in the weeks following the inspection.

The staff team comprised of the centre manager (on sick leave at the time of the inspection), 2 social care leaders, 17 social care workers, one housekeeper and one chef.

### **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:

- The centre's statement of purpose and function
- The centre's policies and procedures
- The young people's care plans
- The HSE monitoring officer's report
- The young people's care files
- Administrative records
- Details of physical restraint/intervention (40) for previous twelve months
- Details of unauthorised absences (30) for previous twelve months.
- previous inspection report and follow-up report
- 3 questionnaires completed by young people
- 3 questionnaires completed by social workers
- previous inspection report and follow-up report
- An incomplete review of the service
- safety statement
- records of complaints

In the course of the inspection, the inspector interviewed:

- A social care leader,
- The external line manager,
- The HSE monitoring officer
- three social care workers,
- two social workers and two social work team leaders
- one parent
- the psychologist associated with the centre
- Three young people

### **1.2 Acknowledgements**

The inspector wishes to acknowledge the co-operation of the young people, their families, the social care leader and staff of the centre, the social workers and external managers and others who participated in this inspection.

### **1.3 Management structure**

The centre manager reported to the regional manager for residential childcare. The external management structure consisted of a regional residential child care manager 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.

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

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

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

<b>Young Person</b>	<b>Age</b>	<b>Legal Status</b>	<b>Length of Placement</b>	<b>No. of previous placements</b>
# 1 (female)	15	Voluntary care	7 months	None
# 2 (female)	14	Care Order	4 months	2 foster care 1 residential
# 3 (female)	13	Voluntary Care	10 days	4 foster care 1 residential

## 2. Analysis of Findings

The centre had previously been inspected by SSI in 2008 and the majority of recommendations arising from that inspection were met.

There were three young people resident in the centre at the time of the inspection. An additional young person who had lived at the centre previously had maintained their placement there while accommodated in a more secure placement for a fixed period of time. Two of the young people had been resident for 4 and 7 months respectively, and the third young person had only lived in the centre for three weeks. Young people were observed engaging positively with staff during the inspection. The parent of the young person recently admitted was extremely happy with the service provided.

At the time of the inspection the centre manager was on sick leave and two social care leaders were deputising in her absence with regular monitoring from external managers. Inspectors found there was some conflict within the management team of the centre which needs to be resolved. Inspectors also found some areas of governance had deteriorated in recent months despite ongoing input from external management. Information required for the inspection process was not provided promptly despite repeated requests and some information provided was incorrect and had to be corrected. The HSE monitoring officer and regional manager for residential childcare were in the process of conducting a review of the service at the time of the inspection.

At the time of inspection this centre was providing a good overall level of care to the young people who were resident in the centre and staff presented as committed and caring. The centre had introduced a new model of care, the Trauma model, 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.

A young person had recently moved into the centre and this had created a disruptive dynamic in the group. The authority of staff was being challenged by young people and there was evidence that young people were disregarding rules and testing boundaries. Young people were disregarding rules and this was affecting the authority of the staff team. There were also a high number of incidents involving some young people who had displayed significant and complex challenging behaviour in the last two years. These issues are described in further detail in *Management of Behaviour* and *Management and staffing*.

Professionals external to the centre spoke well of the commitment of the management and staff team but remarked that administrative issues had arisen in recent months and staff appeared stressed on occasion.

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

### *Purpose and Function*

The centre's purpose and function was to provide "high quality care for up to five young people" aged 10-17 years. The inspectors were concerned about the inclusion of children under twelve years within the target group for residential care. At that time of the last inspection the regional residential child care manager in the area explained that such placements would only be considered in the most exceptional circumstances and that alternative placement with relatives or foster carers would be the initial placement of choice. This was reflected in the centre's statement of purpose and function but inspectors advise the HSE National Policy in relation to "*The placement of children aged 12 and under in the Care of the Health Service Executive*" is also referenced in the statement.

### *Vetting*

Inspectors viewed a sample of personnel records which held the required references and garda clearances. The monitoring officer keeps a database of staff vetting and was satisfied that all files were up to date and satisfactory.

### *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. It showed there had been three planned discharges and four planned admissions in the year prior to the inspection. The register contained the details of the follow-on placements for young people discharged. Inspectors advise 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.

### *Monitoring*

The standard on monitoring was met. The monitoring officer had been visiting the centre weekly in recent months due to the absence of the manager and ongoing governance issues. She informed inspectors that despite repeated requests she had not received notifications from the centre since mid November 2010. However, because of her frequent visits to the centre and her membership of the regional Therapeutic Crisis Intervention (TCI) monitoring committee she was aware of these events in the centre. As described elsewhere in this report there were concerns regarding governance in recent months and this included notifications of significant events to the monitoring officer and the sign off of these events by social care leaders. The monitoring officer advised inspectors she had received some of the outstanding notifications two weeks after the inspection. The centre received written HSE monitoring reports which were also sent to the Social Services Inspectorate and one report was issued in the year prior to the inspection.

### *Suitable placement and admissions*

Both the external manager and supervising social workers were satisfied that the young people were suitably placed in the centre and that it would meet their needs as outlined in their care plans. One young person had been moved to a more secure placement for a fixed period of time and her placement at the centre had been maintained. She was beginning a transition process to move back to the centre at

the time of the inspection. Admissions are processed through a regional admissions panel and all admissions are planned

#### *Contact with families*

A record of contact with family was held on young people's care files. Contact consisted of telephone calls, visits by family to the centre and visits to family homes. One young person had been visiting home for overnight stays but these were suspended at the time of the inspection due to concerns regarding risk taking behaviour. A meeting was due to be held about this following the inspection and the relevant social work team leader confirmed with inspectors that this meeting went ahead with positive outcomes for the young person. Inspectors interviewed one parent on the second day of the inspection. This parent was attending a review meeting in the centre on that day. She spoke highly of the service offered to her child by the centre and the regional residential service as a whole. She told inspectors that staff kept her fully informed of any issues or events involving her child and that staff were kind and approachable. She said that she knew her child was "safe" in the centre and that her child would get "the help she needs". When inspectors discussed the young people smoking, she said she would like to see incentives and smoking cessation programmes offered to young people in the centre.

#### *Emotional and specialist support*

Access to specialist services was very good. 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 being carried out and this yielded positive outcomes for some young people in the management of behaviour, however the introduction of the model was still in its early stages. There was evidence on care files of specific work of a high standard undertaken by staff with young people around risk taking behaviour, choices and personal wellbeing.

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. 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 had dealt with very challenging behaviour in the past two years and were committed to improving responses to negative behaviour in line with the new model of care. The centre also availed of the services of a Guidance Worker within the HSE West residential services. This person was available for advice and guidance in relation to specific needs of the individual young people.

#### *Preparation for leaving care*

Placements in the centre usually lasted three to six months. This allowed time to address young people's risk taking behaviour and emotional needs. In the 12 months prior to the inspection, young people who were discharged moved onto another residential or foster care placement, and occasionally a reunification with their family. Inspectors examined records that showed staff maintained contact with young people after they had left the centre and in some cases, visited young people in their onward placement which was good practice.

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

Inspectors found that care files were well structured and held all of the required documents. Files were of a good 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 advise that this location is recorded in the register for each recorded discharge to assist any young person seeking their files in the future.

### *Care of young people*

The centre provided an overall good quality of care to young people. Young people were valued by staff and were encouraged to work through the issues that led to their placement. They were encouraged to attend and participate in reviews, consulted about weekly menus; had opportunities to choose the décor and personalise their rooms. Inspectors joined staff and young people at a meal and observed staff engaging warmly and positively with young people. Young people informed inspectors there was some staff they identified with and trusted.

The centre had developed very positive placement plans for each young person following their admission to care. Placement plan meetings are held every two weeks.

Young people had mixed opinions on the authority of staff. They felt staff had little authority to enforce some rules but responded excessively in other situations (*see Consultation with young people and Management of behaviour*). Inspectors found this was connected to the lack of clarity staff had in the introduction of the model of care and issues with governance and supervision.

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 money. 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 in light of the financial constraints of the economy. 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. A cook was employed on a part time basis and young people said they really enjoyed the food provided.

### *Safeguarding and Child protection*

The staff team were clear about safeguarding and child protection. They had a good awareness of safe care practices and the need for appropriate boundaries. At the time of inspection, the inspector found one allegation made by a young person against a staff member and the external manager had responded swiftly to this. The investigation was ongoing and the external manager had ensured all protective factors were in place. The young person informed inspectors she was happy with her allegation being treated seriously. The supervising social worker informed

inspectors she was notified about the allegation and was satisfied with the response by the centre.

#### *Accommodation*

The centre was spacious, homely and comfortable. There was a kitchen, a dining room, a living room, two bathrooms and a quiet room for young people's use. The young people had individual bedrooms which they had personalised to their own tastes. There was ample car parking for staff and visitors and there was good quality playground equipment and a basketball court which was used regularly by young people.

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

##### *Management and Staffing*

The manager had been in post for over eight years. She had been on sick leave for over three months at the time of the inspection. She returned to the centre three weeks after the fieldwork. There were two social care leaders in post who were part of the management team in the centre and they were deputising for the manager in her absence. This had resulted in some lapses in areas of governance, such as notifications and staff supervision.

The regional manager for residential childcare and HSE monitoring officer had set up weekly on site meetings with social care leaders to monitor the day to day management of the centre and this commitment to monitoring and supporting the team was commendable. However, there were still ongoing issues in these areas. Inspectors were concerned to find that requests made for information during the inspection were not responded to in full or in a timely manner and were only provided after repeated requests.

Incorrect information was initially provided, for example inspectors were initially informed there had been 6 physical interventions/restraints. This was subsequently corrected by the second social care leader on their return to 40 physical interventions/ restraints.

Inspectors also found that members of the staff team and senior staff had not complied with simple administrative requests over a period of months. More serious regulatory requests to notify the HSE monitoring officer of serious incidents involving the children were also not complied with despite specific directions from line management. The regional manager had addressed the non-reporting of significant events but this had still not brought about the desired change and this non-compliance raised concerns about the accountability of the team to external governance. This needs to be addressed further and monitored closely.

Inspectors determined from various sources that there had been some difficulties within the management team in the past year. These difficulties related to differing management styles, communication issues and some variances in ethos. In addition, the centre introduced a new model of care. The external line manager of the centre had worked with all parties to reach a resolution to the conflict within the management team but the situation had not been fully resolved at the time of the inspection due to the fact the manager was on sick leave.

Inspectors found that a result of these difficulties and changes, the staff team lacked cohesion at times and there was some confusion regarding approaches to some care practices such as the management of behaviour. It is imperative that the management team provide cohesive and consistent leadership to staff, for the benefit of the service to young people.

The external line manager advised inspectors that a third social care leader was due to take up a post following the inspection. Staff sickness levels were high at times in the year prior to the inspection and the external line manager was involved in addressing this issue. Inspectors recommend the HSEWA ensures that the management team address and resolve the outstanding difficulties and conflict as a matter of urgency.

#### *Supervision*

The standard on supervision was partly met as formal supervision was irregular or had lapsed for some staff in the past year. Given the difficulties in governance, the impact of this on the team, staff sickness levels and the introduction of a new model of care, staff needed regular supervision to provide consistent leadership and address any issues with the changes in practice. Inspectors recommend that all staff receive regular formal supervision immediately.

#### *Training and Development*

The standard in relation to this was mostly met. Centre staff had participated in training in therapeutic crisis intervention, supervision, child protection, first aid and food hygiene since the last inspection. Records provided to the inspectors showed that three staff had attended training on the new model of care in the centre, the Trauma model. However, the external line manager advised inspectors following the inspection that the staff team have received two sessions of training regarding the Trauma model. Records also showed that one staff member had attended risk assessment training but the external manager has since confirmed that several staff had attended in house risk management training and this is part of the core training provided regionally. As the centre has introduced the Trauma model of care, Inspectors recommend that the HSE ensures all staff are trained in this model, are confident in its use and in risk assessment (for those who have not received it) which is essential, as many young people are admitted to the centre because of risk taking behaviour.

#### *Administrative files*

As stated previously, there was some deterioration in the upkeep of administrative records in recent months. Inspectors found the complaints and fire records were not up to date. Some fire drill records for 2010 were found in a drill record for 2004. The centre manager has since advised that a separate record was maintained but this was not provided to inspectors during the inspection. Inspectors recommend that all administrative records are checked and any omissions rectified.

#### *Social work role and supervision and visiting of young people*

The young people all had supervising social workers. There was evidence that they have regular contact with the young people and attend fortnightly placement plan review meetings. One of the three social workers had not read the care files in the centre. The inspector recommends that social workers read care files and centre records from time to time as required by the standards.

### *Care Plans and Reviews*

Each young person had a care plan which was subject to a statutory review. However, in one case the updated care plan was not on the young person's care file. The supervising social worker informed inspectors that staff at the young person's previous placement had agreed to forward the plan. The inspector recommends that the updated care plan be forwarded to the centre immediately. Consultation had been carried out in the drawing up of the plan; and all care plans on file were dated and signed by the supervising social workers.

### *Unauthorised absences*

Initially inspectors received incomplete and in some cases incorrect details regarding absences. Upon the return of the centre manager from leave, the correct information was forwarded to the authority. There were 30 instances of unauthorised absence from the centre in the previous twelve months in relation to five young people. The duration of these absences were 20 minutes to 74 hours. One young person currently resident in the centre was missing for significant periods of time, and in one month was missing for 147 hours in total. This had been managed by the 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 Síochána nationally to address the issue of absconsions from residential units. This young person was engaging in risk taking behaviour while absent and the supervising social worker informed inspectors plans were now in place to ensure this young person was kept safe. As described previously, the HSE monitoring officer was not informed of all relevant events and supervising social workers were at times only informed verbally of events. Inspectors recommend that all relevant parties are notified of absences and events as per the regional procedure.

### *Physical restraints*

Initially inspectors received incomplete and in some cases incorrect details regarding physical interventions and restraints. Originally inspectors were advised there had been six instances of intervention/restraint but on the return of the other social care leader from leave the correct information was forwarded to the inspectorate. This showed there were 40 instances of physical intervention/restraint in the year prior to the inspection.

Physical interventions consisted of blocking young people's movements or standing between young people if staff feel a situation is escalating. Physical restraints are used in extreme situations to prevent a young person from harming themselves or others. Inspectors found that interventions were used appropriately and noted that restraint durations were short, ranging from five seconds to three minutes. All staff were trained in Therapeutic Crisis Intervention (TCI), the accepted method used in the HSE for physical interventions.

These were reviewed by the TCI monitoring and review committee. The function of the committee is to ensure that crisis management strategies are implemented safely in the centres.

### *Children's Rights and consultation*

This was mostly met but the consultative aspect of children's rights needed some improvement. The young people were informed of their rights on admission. The regional residential service has a complaints policy for all young people in care. The children and young people have access to their care files. The young people

currently in the centre have not read their files but are aware of their right to do this. Records showed there had been four young peoples meetings and one community meeting since October 2010. Young people refused to attend two of these meetings in December 2010. Young people expressed concern that the recent community meeting held was uncomfortable, as the young people's disruptive behaviour was the topic of the meeting, and there were only two young people and too many staff there.

Inspectors reviewed the meeting minutes and found that there were 11 staff in attendance with two young people. Staff must be mindful of the power balance in such situations and ensure young people do not feel uncomfortable in a forum that is supposed to engage all parties in expressing any concerns and seeking solutions. Young people expressed concern to inspectors regarding certain rules around mobile phones, supervision, bedtimes and pocket money, and they should be engaged in a forum that gives them an opportunity to discuss these issues openly and seek resolution. Inspectors have seen a community meeting held in another service in the region and this worked extremely well and was collusive.

Inspectors recommend that community meetings are held regularly and that attendance is not excessively made up of staff.

#### *Complaints*

The centre's complaint record was not up to date as the last recorded complaint was in March 2010 but inspectors were aware of complaints made since that date. Young people informed inspectors they were aware of how to make a complaint and all named staff they would talk to if they were concerned. Inspectors were provided with evidence that young people's complaints about staff were taken seriously and responded to swiftly by the regional residential child care manager. However, inspectors were concerned to see a joint complaint was made by a staff member and a young person regarding the heating system. The external line manager informed inspectors that she met with the staff member immediately upon receipt of the letter to address the concern regarding the joint complaint. Staff complaints should not be incorporated into young people's complaints as this is an inappropriate use of a system that is for the sole use of those receiving the service. Staff have several forums such as staff meetings, supervision and grievance processes to raise any concerns they have. Inspectors recommend that the complaints record is brought up to date immediately and maintained.

#### *Managing behaviour*

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

From late 2009 to mid 2010, the centre experienced serious challenges in managing the behaviour of one young person who had very complex needs and presented the team with very challenging behaviour. There were 170 significant incidents in 2010. 129 of these related to one young person who was only resident in the centre for six months of 2010. There were 46 incidents relating to the same young person in 2009.

A lot of these incidents consisted of physical assaults on staff, threatening behaviour and sexual threats. Staff were under significant pressure and they struggled to manage these behaviours effectively. On some occasions several incidents occurred

in the one day. However, staff demonstrated a strong commitment to this young person, maintaining ongoing contact after their discharge. Overall there were a high number of incidents involving some young people in the last two years and the management of behaviour has been an ongoing issue for the team.

The centre has introduced the trauma model of care which has had a positive effect in other services in the region. The model is still in the early stages of introduction in the centre and a review of the service is being carried out by the regional residential child care manager and monitoring officer which should help the team to reflect on the aspects of the service that work well and that need improvement.

There were 18 significant incidents in December 2010, relating to two young people currently resident in the centre. These incidents mostly related to disruptive behaviour around rules. Young people told inspectors there were rules they didn't like, and some they didn't understand (such as being allowed a mobile when outside the centre, but not when inside). As a result, they said they refused to comply with certain rules such as handing in their mobiles or not smoking inside the centre. Inspectors observed some of this behaviour during the inspection.

Staff that spoke to inspectors were committed to the new model of care and its focus on relationships and understanding in managing behaviour, but they felt unsure about how to respond to certain behaviours or incidents. As a result, there were lapses in staff authority at times when young people refused to comply, or excessive responses (such as calling gardai) when young people were disruptive. This may be a combination of the early stage of the model, staff confidence and young people not understanding some rules. Inspectors advise that if the improvements needed which are highlighted in this report are addressed, such as resolution in the management team, trauma model training for staff, regular staff supervision and formal consultation with young people, this will support an improved and cohesive response to the management of behaviour. Inspectors recommend that the management of behaviour is improved to be consistent and proportionate. Inspectors also recommend the staff team are provided with a formal forum to identify any residual concerns or inconsistencies staff may be experiencing relating to the service vision and the new model of care.

#### *Health*

The standard of primary care and practice in relation to health care was good. The staff team promoted the health of the young people and responded to medical needs as necessary. All the children had been maintained with their family general practitioner and also had a choice of a male or female doctor. All had a medical examination on admission. Records of medication administered to young people were held on care files.

All three young people smoked and one of these was under 16. This young person's parent confirmed to inspectors she had given permission for this as the young person's needs relating to her behaviour were the primary concern currently. This parent said she would like to see incentives and smoking cessation programmes offered to young people in the centre and Inspectors recommend these are actively put in place.

#### *Education*

Staff informed inspectors that practice in the centre promoted and emphasised the importance of education and achievement for each young person. All the young

people had school placements, but only one young person attended school during the inspection. This young person's school placement was located in her local community which was located a significant distance from the centre, but staff had supported her to maintain this placement which was commendable. The remaining two young people had been engaging in disruptive behaviour late at night around the time of the inspection and were refusing to attend school. One of these young people has had sporadic attendance at school because of risk taking behaviour and complex emotional needs. Staff were confident that this behaviour was diminishing and that young people would return to school quite quickly. Inspectors recommend that the school attendance of these young people is monitored closely and any continued absence is addressed swiftly. The centre has an on site classroom facility which it can use when a young person does not have a school placement.

#### *Fire Safety*

The centre had a fire certificate and written confirmation from a certified engineer that all statutory requirements relating to fire safety and building control have been complied with as required by standard 10.. Records of three fire drills for 2010 were found in three separate (out dated) records, but still reflected that fire drills had not taken place on a regular basis. No drills had taken place at night. Given that the centre is a short term facility, management and staff should ensure that fire drills take place shortly after each new admission to the centre. Inspectors recommend that fire drills are held regularly including at the time of a new admission to the centre, recorded fully and held at varying times of the day/night.

#### *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. Inspectors recommend that a health and safety audit of the premises is undertaken.

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

#### *Notification of significant events*

This standard was not met. The centre had a policy on reporting significant events to include classified 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. The social care leader and staff informed inspectors that notifications were sent to the local monitoring committee, young people's social workers and the HSE monitoring officer. However, the HSE monitoring officer informed inspectors that she had not received the necessary notifications of significant events from the centre in over two months, despite repeated requests regarding these. All social workers informed inspectors that they were satisfied that staff notified them of significant events verbally but one social worker stated she had no written communication of significant events since November 2010. As stated previously, Inspectors found deficiencies in this area of governance and recommend that the current practice in the centre relating to notifications is reviewed, any outstanding notifications are made and all notifications are sent to all relevant parties in a timely manner.

### 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		√	

**Recommendations:**

- 1. The HSEWA should ensure that the management team address and resolve the outstanding difficulties and conflict as a matter of urgency.**
- 2. The HSEWA should ensure the management and staff team are fully accountable in their roles to external line management.**
- 3. The HSEWA should ensure that all staff receive regular formal supervision immediately.**
- 4. The HSEWA should ensure that all staff are trained and confident in the Trauma model of care and in risk assessment.**
- 5. The HSEWA should ensure that all administrative records are checked and any omissions rectified.**
- 6. The HSEWA should ensure that the current practice in the centre relating to notifications is reviewed, any outstanding notifications are made and all notifications are sent to all relevant parties in a timely manner.**

**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	√		

##### Recommendations:

7. **The HSEWA should ensure that community meetings are held regularly and that attendance is not excessively made up of staff.**
8. **The HSEWA should ensure that the complaints record is brought up to date immediately and maintained.**

## 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	<b>N/A</b>		

### Recommendations:

- 9. The HSEWA should ensure that the relevant updated care plan is forwarded to the centre immediately.**
- 10. The HSEWA should ensure that social workers read care files and centre records from time to time as required by the standards.**

## 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

- 11. The HSEWA should ensure that the staff team are provided with a formal forum to identify any residual concerns or inconsistencies staff may be experiencing relating to the service vision and the new model of care.**
- 12. The HSEWA should ensure that the management of behaviour is improved within the centre to be consistent, proportionate and in keeping with the regional policies and procedures**
- 13. The HSEWA should ensure that all relevant parties are notified of absences and events as per the regional procedure.**

## 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	√		

## 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:

14. The HSEWA should ensure that the school attendance of the young people identified is monitored closely and any continued absence is addressed swiftly.

## 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:

15. The HSEWA should ensure that incentive and cessation programmes are 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		√	

### Recommendation:

- 16. The HSEWA should ensure that fire drills are held regularly including at the time of a new admission to the centre, recorded fully and held at varying times of the day/night.**
- 17. The HSEWA should ensure that health and safety audit of the premises is undertaken.**

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

- 1.** The HSEWA should ensure that the management team address and resolve the outstanding difficulties and conflict as a matter of urgency.
- 2.** The HSEWA should ensure the management and staff team are fully accountable in their roles to external line management.
- 3.** The HSEWA should ensure that all staff receive regular formal supervision immediately.
- 4.** The HSEWA should ensure that all staff are trained and confident in the Trauma model of care and in risk assessment.
- 5.** The HSEWA should ensure that all administrative records are checked and any omissions rectified.
- 6.** The HSEWA should ensure that the current practice in the centre relating to notifications is reviewed, any outstanding notifications are made and all notifications are sent to all relevant parties in a timely manner.
- 7.** The HSEWA should ensure that community meetings are held regularly and that attendance is not excessively made up of staff.
- 8.** The HSEWA should ensure that the complaints record is brought up to date immediately and maintained.
- 9.** The HSEWA should ensure that the relevant updated care plan is forwarded to the centre immediately.
- 10.** The HSEWA should ensure that social workers read care files and centre records from time to time as required by the standards.
- 11.** The HSEWA should ensure that the staff team are provided with a formal forum to identify any residual concerns or inconsistencies staff may be experiencing relating to the service vision and the new model of care.
- 12.** The HSEWA should ensure that the management of behaviour is improved to be consistent, proportionate and in keeping with the regional policies and procedures.
- 13.** The HSEWA should ensure that all relevant parties are notified of absences and events as per the regional procedure.
- 14.** The HSEWA should ensure that the school attendance of the young people identified is monitored closely and any continued absence is addressed swiftly.
- 15.** The HSEWA should ensure that incentive and cessation programmes are offered to young people to discourage smoking.

- 16.** The HSEWA should ensure that fire drills are held regularly including at the time of a new admission to the centre, recorded fully and held at varying times of the day/night.
- 17.** The HSEWA should ensure that health and safety audit of the premises is undertaken.