Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

A CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE NORTH EASTERN AREA

INSPECTION REPORT ID NUMBER: 452

Fieldwork Date: 3rd and 4th February 2011
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1. Introduction

The Health Information and Quality Authority (HIQA) Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Health Services Executive (HSE), North East Area (NEA) under Section 69 (2) of the Child Care Act 1991. Nuala Ward (lead inspector) and Mike McNamara (co-inspector) carried out the inspection over a two day period from the 3rd to the 4th of February 2011.

The centre provided medium to long term care to five children aged between 12 and 18 years of age. Up to March 2009, admissions were from the local health areas of Meath, Louth, and Cavan/Monaghan. However, since then the centre has provided a residential care service for children from the entire HSE North East region which included the three North Dublin local health areas.

The centre was situated in a detached house in an estate in large town. At the time of inspection there were five children in the centre: one girl, and four boys. Two of the boys were brothers. The youngest child in the centre was 12 years of age and the eldest was 16 years.

The centre had been inspected previously in October 2006 and May 2009 and the reports can be accessed on the Authority's website www.hiqa.ie, as inspection reports 162, and 323.

1.1 Methodology

The judgements of inspectors in relation to this inspection are based on an analysis of findings verified from a number of sources of evidence gathered through:

- observation of practice
- examination of records and documentation, including:
  - The centre's statement of purpose and function
  - Policies and procedures
  - Children's case files
  - HSE monitoring officer's report on the centre
  - Census forms on management and staff
  - Administrative records
  - Previous inspection report and follow-up report,
  - Health and safety documents,
- interviews with the following:
  - Four children in residence
  - The deputy centre manager
  - The regional and acting deputy manager for residential services
  - Four social workers
  - One social care leader and 2 social care workers
  - Two HSE monitoring officers
  - One parent, and
- an inspection of accommodation.

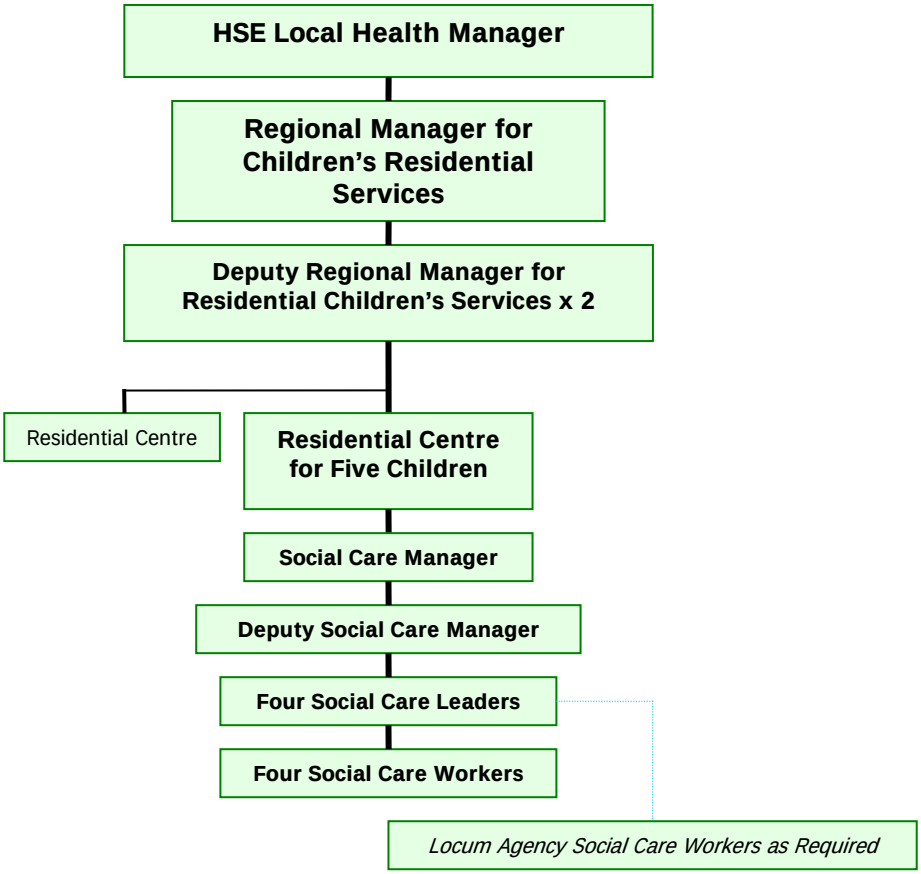
1.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the children and their families, staff members and other professionals who assisted during this inspection.

1.3 Management structure

The centre was managed by a centre manager who was assisted by a deputy social care manager. The centre manager reported to the deputy regional residential care manager who had direct operational responsibility for this service.

The deputy regional manager for children's residential services reported to the regional manager for residential services in the local health areas of Meath, Louth and Cavan/Monaghan and North Dublin. The Local Health Manager with specific responsibility for child care services for HSE Dublin North East had overall line management responsibility for the residential children's services in these four LHO areas.



1.4 Data on young people

During the 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*	*Number of previous placements*
# 1 (boy)	16 years	Statutory Care	15 months	One residential placement
# 2 (boy)	16 years	Voluntary Care	6 months	One short term respite residential placement One relative care placement
#3 (girl)	16 years	Statutory Care	4 months	Two respite foster care placements Two foster care placements Two residential respite placement
# 4 (boy)	14 years	Voluntary Care	4 months	One short term respite placements
# 5 (boy)	12 years	Voluntary Care	4 months	One short term respite placements

2. Summary of Findings

There was some evidence of good practices in the centre. Children had a good awareness of their rights, and some of them spoke highly of individual staff members. Inspectors interviewed staff and found that they were committed and child-centred and clearly showed that they cared about the children in the centre. There was evidence of good keyworking and individual work with the children.

However, inspectors found that the outcomes for children placed in this centre were extremely poor. Placements of five out of six children that had lived in the centre in the 12 months prior to the inspection had ended abruptly, and children were subsequently placed in detention, secure care or private residential facilities.

Inspectors were concerned to find that there were numerous incidents of aggression between children in the centre and outside in the community. One young person had been removed from the centre by a parent following a serious physical assault by another young person. Two of the young people were involved in criminal activity in the locality. While inspectors found that staff members presented as caring and warm towards the children, the strategies and measures used to manage risk and unacceptable behaviour did not work. The impact of this was that the centre was unsafe at times and children had unplanned transfers to different services. This was unacceptable and the HSE should immediately review the capacity of this service to fulfil its function in providing safe care for the children placed there. Following the fieldwork the HSE North East provided the Authority with immediate actions taken to address some of the key issues. These included weekly on-site visits by the line manager, specific tasks for the centre manager and staff team and three weekly visits by the HSE monitoring officer.

Due to the inspectors' concerns about this centre, as described in further detail in the report, the Authority will carry out a second inspection within two months of the publication of the report to gauge the impact of the actions taken by the HSE and compliance with recommendations.

Overall, inspectors found that there were six areas of practice in which the centre met the required standard.

Recommendations from this inspection related to the functioning of the centre, behaviour management, discharges of children, management and staffing, safety of children, supervision of staff, maintenance and fire safety.

Practices that met the required standard

Primary Care

The children in the centre received a good quality of primary care. They were well presented and enjoyed a variety of good food. They had sufficient clothing, received pocket money and went on activities. Within the rules of the centre, they were allowed to have mobile phones. Their health needs were met and all had a GP they could visit. Three of the young people told inspectors they liked members of staff team and could name staff members they would talk to if they had difficulties or concerns. Inspectors observed warm and good humoured interactions between the staff members and young people. One meal attended by inspectors was a relaxed event with lively conversation and an atmosphere of fun and respect between the two younger children and staff. There was a strong nurturing ethos towards the children and there was evidence that staff members cared for the children, and were concerned about their well being.

Care practices were supported by comprehensive, well developed regional policies for the Dublin North East residential services.

There were 10 social care staff posts filled by 3 child care leaders and 7 child care workers (1 was a full time relief worker). The most recently appointed staff members had been appropriately vetted with the required Garda checks and three references. Seven staff had social care qualifications, and four had other relevant qualifications. One staff member was unqualified. The staff team was well deployed to meet the needs of the young people with three staff members on duty each evening. There were regular staff meetings and handover meetings. There was a senior psychologist for children's residential services who provided training to staff teams, attended staff meetings regularly and provided guidance on the care of the young people.

Monitoring

The HSE monitoring officers visited the centre twice in the previous six months. A second HSE monitoring officer had been recently appointed for services for children in care in the area. A draft report on their findings from their visit in December 2010 was available at the time of inspection. This report highlighted some key issues in relation to unsafe behaviour by the young people which was impacting on group dynamics and non-school attendance. These findings remained an issue at the time of this inspection.

Emotional Support
A senior clinical psychologist provided support to the staff team in working with the young people on specific areas such as improving self-esteem, and encouraging young people to express anger in safer ways. This psychologist also worked with two young people in centre on an individual basis. The individual needs of each young person were assessed through a placement development plan which subsequently informed interventions between the staff team and the young person. The process was led by keywork co-ordinators, the centre manager and the senior clinical psychologist. This process was currently being reviewed by an external consultant with a revised version in development at the time of inspection.

Care files and administrative files
The centre's care files and administrative records were well maintained.

Health
The staff team worked with the children individually, discussing their health, including sexual health and wellbeing. Four of the children had a medical assessment on admission to the centre and one did not but had a medical assessment three months prior to his placement.

Children's Rights – consultation and complaints
The standard was met. The children had a good understanding of their rights, and information about their rights was prominently displayed. A representative from the Irish Association of Young People Children in Care (IAYPIC) had met contacted by the centre to advocate for one young person. This was good practice and reflected a child-centred ethos in the centre. The standard on consultation was good. Some of the children that attended their care planning meetings felt that their views were heard.

Children were aware that they could access their records and two young people had done so recently. There was a good complaints policy. The children knew how to make a complaint and could identify people they could make a complaint to. They were confident their complaints would be listened to and addressed either by the staff team or by their social workers. In the year prior to the inspection there had been two complaints made by two children. One had been addressed promptly to the satisfaction of the young person and the investigation into the other was ongoing at the time of the inspection. Inspectors noted that the complaint register had details of a complaint made by a staff member against a young person who had called them names. This was not appropriate and such matters should be dealt with in the context of management of behaviour.

Practices that partly met the required standard

Management of the centre
The centre manager had a relevant qualification and significant management experience. She was assisted by a deputy social care manager who was qualified and had numerous years of residential experience. There had been significant changes in the line management of the service. A new regional manager had commenced in October 2010, and a new line manager had started the week prior to inspection.

Inspectors were concerned that, despite numerous serious incidents in the centre and the poor outcomes for children, in the year prior to inspection there had been no external review of this service by line management.

Staff told inspectors that while there were regular debriefing sessions there had been no internal review of care practices following serious incidents. There was a lack of reflective practice and inspectors were concerned that staff members did not have sufficient skills or training in addressing high risk behaviour. Inspectors were informed that the HSE North East had a critical incident review group that had been incorporated into the HSE Dublin North East Quality and Risk Group but it was not clear to inspectors how this process influenced practice in this centre. These findings are discussed further in the report.

External managers should regularly monitor the management of the centre, care practices, care records, and practice in respect of supervision. They should evaluate the effectiveness and standards of all aspects of care, ensure that children in the centre are safe, and give direction to the manager and staff where practice falls below standard. The HSE monitoring officer should work closely with the centre and line management in evaluating the quality of the care to children and compliance on issues raised in the monitoring reports.

Child safety and protection
The staff team had a good understanding of the child protection system and safeguarding practice internal to the centre. Inspectors found that they had appropriately notified serious concerns to the social work department.

There were five notifications by the centre to supervising social workers of child protections concerns about three young people living in the centre. One of these related to an alleged incident of inappropriate behaviour between two young people. This was being managed appropriately by the social workers involved.

Three notifications related to concerns about one young person regularly absconding from the centre and engaging in criminal and unsafe behaviour. No child care case conference had been called in response to the notifications sent by the centre to supervising social workers. Instead, regular strategy meetings occurred between the social work department and residential staff members.

However, despite these regular meetings inspectors found that residential managers and staff did not have key information about how the social work department was addressing some of the concerns about this child with An Garda Síochána. Inspectors found that different professionals had significantly different views regarding the risks associated with this child. These issues impacted on the planning for the child and the

centre's capacity to address their needs and manage the risks arising from their unsafe behaviour.

The fourth notification related to an alleged incident of inappropriate contact between two young people, one of whom had since left the unit. There was a significant delay in (four months) in assessing this allegation and no outcome had been reached at the time of the inspection. One of these young people also made a disclosure about a previous placement and this was also not being managed by the social work department through the child protection notification system. There were significant delays in the criminal investigation of the case. The young person in question told inspectors that this delay was a source of anxiety as it had been eight months since the disclosure had been made by this young person. While the social worker and centre staff were advocating on their behalf with the relevant agencies this delay was impacting negatively on the child's well being.

The management of these concerns was a concern to inspectors. All outstanding inter-disciplinary issues should be addressed immediately. The strength of convening child protection case conferences is that all agencies including members of An Garda Síochána share information, evaluate the risk of harm and put in place an agreed strategic plan. Any delays in progress can be easily identified and addressed within such procedures.

Social work and care planning

Inspectors interviewed four social workers and this was the first time they had placed children in this centre. They acknowledged positive aspects of the service and two social workers commented positively on the care to children. All social workers acknowledged that some staff were very caring towards the children but some social workers expressed significant concerns about the inability of the centre manager and staff to effectively manage challenging behaviour by some of the children. Two social workers were seeking alternative placements for their children.

The social workers told inspectors that communication between themselves and the centre was good and they were confident that they would be notified of all significant events. Some social workers preferred if written records were faxed to them rather than posted due to the delay in receiving key information. They understood the necessity of reading records in the centre, and three of the social workers had done so.

Care plan reviews had occurred on a regular basis for the young people, but there was only two up to date care plans on file. It is a requirement of the regulations that all care files have up-to-date care plans. Decisions to move children into alternative placements were not being made in a care planning process in consultation with the children and their families. The care plan review meeting allows all significant people including the young person and family members to be involved in any planning decisions. As a basic safeguard decisions about placements should occur within this forum or in emergencies, reviewed very soon after. Concerns about prolonged non-attendance at school or training placements were not addressed in a care plan review process.

Register
The register did not include all information required by the regulations. There was no evidence of where a number of the children who had lived at the centre had been discharged to. This is a requirement of the regulations and should be remedied without delay.

Family contact
The standard on family contact was met in part. There was regular phone contact with family members and parents. The staff team facilitated weekly contact for two children, and parents had visited the centre. Inspectors interviewed two parents, and while they spoke well of the staff team they also highlighted concerns about risk presented to their children by other children in the centre. One parent was especially unhappy with delays in investigations into child protection issues. Both parents told inspectors that they were dissatisfied with the quality of communication from the social work department as some information was not shared with them. The relevant social workers should meet with parents and address these concerns.

Staff supervision
The centre had a policy on formal supervision but it did not occur on a regular basis. The standard of supervision when it occurred was good. Inspectors found that some staff members had not received supervision for a number of months. Considering the specific challenges in the team this was not satisfactory. The centre managers need to ensure that supervision occurs on a regular basis in accordance with HSE policy. The centre manager had only two recorded sessions of formal supervision with the previous line manager. Considering the particular challenges in the centre, and the need for accountability in the provision of a residential service for children, this was not sufficient.

Individual care and group living
The centre had a games room, and there were games and books in evidence. However, the young people did not have access to a computer or to the internet. This should be given serious consideration by the managers of the centre, since it does not fulfil the requirements of the standards as it puts the young people in the centre at a disadvantage to their peers in the community, and in respect to the pervasive use of information technology in a modern society, does not allow them to develop the skills, competence and knowledge necessary for adulthood and citizenship. Any access to the computer and internet should be managed safely and appropriately in a manner similar to their peers.

Premises and safety
The centre was spacious and adequate for the number of young people to whom it provided a service. The general décor and furnishings in the interior of the house were of a reasonable standard, and the accommodation was homely. However, there were signs of significant wear and tear in the fabric of the building (such as cracks in the plaster next to door jambs, and small holes in plaster) and there were some areas of the building in which repairs were needed for a considerable period of time. The walls of several rooms had been painted by staff.

There was space, with two sitting rooms, for young people to meet visitors, family friends and professionals, in private. Most of the young people's bedrooms were spacious, but the rooms of more recently admitted young people were sparsely personalised and functional rather than comfortable.

The centre had valid up-to-date insurance. Inspectors examined a sample of the maintenance records and found that the response to requests for repairs was generally good.

The centre had two members of staff who were health and safety officers, one of whom had received training in health and safety. Information from the staff training census provided to inspectors indicated that nine of the staff team were trained in First Aid.

Maintenance
Overall, the centre was maintained to a reasonable standard. Inspectors examined the maintenance register and found that responses to requests for repairs were generally good. However, the register should be revised to record clear dates when repair works are completed. Some of the light fittings were shabby, one was without a working bulb, and one lamp was without a shade. Inspectors did not receive evidence of a rolling programme of maintenance, but parts of the centre had been redecorated by staff since the last inspection. However, the ceilings were not included in that programme of redecoration, and one ceiling, which had substantial damp damage, remained unpainted long after the repair to the plumbing upstairs had been carried out. Overall, the building needed upgrading, particularly the windows, which were single-glazed in hardwood frames that, staff reported to inspectors, neither kept out drafts and the cold nor kept in heat. The laundry room was small. It contained a domestic washer and an industrial-size dryer. The centre generally should have an up to date health and safety risk assessment, but this room in particular should be risk assessed in terms of hygiene, potential accidents and potential fire. The bathrooms were in reasonable condition, but most of them needed new taps, and one shower room had a persistent problem with mildew that was damaging the ceiling.

The exterior of the building needed decoration. It had become weather-beaten and grey over the years since it was last painted. There was an overflowing drain from the laundry room that left slime on the concrete.

External managers were aware of the deficiencies in the accommodation. They have a key responsibility to ensure that the standard of accommodation is high and well maintained. Inspectors recommend that they regularly assess the physical state and safety of the centre and take appropriate remedial measures.

Safety
The centre had a health and safety policy but no updated health and safety assessment. This should be carried out by or with an appropriately qualified and authorised person external to the centre as soon as possible considering the condition of the building. The centre's vehicle had a current tax certificate, and the centre had a letter indicating that it is covered by State's insurance.

Medicines were appropriately stored in a locked metal cabinet, and the medication administration system was good. Prescribed medications were in an inner, double locked cabinet. The range of over the counter medication used by the centre was approved by a pharmacist, and in each instance authorised by the GP. At the time of the inspection none of the young people were on any prescribed medication.

At the rear of the building there was a considerable amount of loose co-axial cabling that needed to be tied down if it is in use, or removed if it is not, since it has potential to be used as a ligature.

Fire Safety
There had been significant improvement in fire safety since the last inspection. The fire equipment was well maintained, and there were regular fire drills. The centre had recent visits by a fire safety officer and a member of staff was a designated fire safety officer. The centre had written evidence of fire safety arrangements in the centre from the HSE regional fire safety officer.

The centre had a fire register. It consisted of three separate records. The fire register should be reviewed with a view to streamlining the relevant recording and making the information in it more accessible. The register showed that all staff had received training in fire prevention and evacuation in August 2010.

The fire precaution/prevention system was regularly serviced by a fire safety company. However, service records were unclear. From examining the fire extinguishers, fire glasses, smoke detectors and alarm system, inspectors found that checks to parts of the system had taken place on four separate occasions in 2010. There was a written note in the fire register indicating that the service company had been to the centre, but not specifying what had been checked. The centre should receive a document after each service itemising the devices that were checked.

There was evidence from the care files that young people in the centre were in possession of cigarette lighters, and the register showed that some evacuations were after the alarms were set off by young people smoking in their bedrooms. Inspectors recommend that a system is established so that, as and when it arises, this issue is notified by the centre to the fire safety officer, and a record kept of the advice received from him/her. On an inspection of the accommodation the inspector found that two fire exit doors were obstructed, one significantly by a small table and items that had been in place for a considerable time. Inspectors recommend that managers of the service arrange for the fire safety officer to visit the centre and assess fire safety practice in order to raise the manager's and centre staff's awareness of fire safety, and to establish a system of regularly reporting risks to him and keeping a record of any advice received.

Practices that did not meet the required standard

Behaviour management
This standard was not met. Despite the efforts of staff to manage difficult and challenging behaviour, there were a number of significant events and incidents in the centre which were of serious concern to inspectors. There had been 112 significant events in relation to nine children in the 12 months prior to inspection. The majority of these incidents (92) were about children being absent at risk from the centre. The remaining were incidents of verbal and physical aggression and incidents of self-harm.

There were a number of systems in the centre which guided the work with the young people including the placement development plans, keyworking and the Professional Management of Aggression and Violence (PMAV) which included physical interventions. The DICES model of risk assessment was also used to plan the management of behaviour with significant levels of identified risk. The staff team

informed the Garda Siochana when children were absent in accordance with the HSE National Protocol. Staff members maintained contact with children by phone when they were absent without permission from the centre and encouraged them to return.

The centre manager had installed an alarm system for the bedroom doors. The staff team attempted to put in place consequences and talked with the young people about their behaviour. There was evidence that despite this the manager and staff lacked sufficient authority and skills resulting in children being at risk in the centre and externally in the community. One of the children had specific challenging behaviour that staff members told inspectors they did not have adequate training or knowledge to adequately manage.

Some of the children were out of control, staying away overnight, engaging in criminal behaviour and being abusive to staff and other young people. One young person was removed from the centre by his parent after he had been seriously physically assaulted by another young person. This was the second time a child had been seriously physically assaulted in the centre by another child in the year prior to the inspection. A third child had also been removed by parents due to concerns about safety during repeated absences. The staff members involved in the most recent incident of physical assault told inspectors they did not have the skills to prevent the child from getting hurt.

One young person was absent from school for a number of months and spent each day in the home of a family in the town not returning until late each evening. The centre staff knew where she was but did not adequately address the child protection concerns associated with these absences. Two other young people were involved in criminal activity inside and outside of the centre and both were involved with the Juvenile Liaison Service of the Garda Siochana. This service aims is to prevent children from becoming involved with the criminal justice system. The two youngest children in the centre told inspectors that some of the incidents they witnessed were 'scary'.

There were regular incidents of verbal abuse and threatening behaviour towards staff members and each other. On occasions, items were stolen from the centre and from other children living there.

Despite these serious incidents and repeated unplanned discharges of children from the centre, there was no evidence that line managers had reviewed any of the incidents or the functioning of this service. This line management in partnership with the centre manager should ensure that practice in the management of behaviour improves and adequate training and direction is provided in this regard.

Admissions and discharges

Children are admitted to the centre through a HSE regional admissions and discharges committee. There was a collective risk assessment process to assist in the decision-making process. However, inspectors advise that this risk assessment system be reviewed as it was not sufficiently robust to identify the risks in a centre prior to the placement of children. It focused on the risky behaviours of children currently in residence but did not assess sufficiently the impact of the new individual. Two siblings aged 12 and 14 years with no previous care history were placed in this centre that at the time were caring for two older criminally active and aggressive teenagers.

The outcomes for five of the six children that had been discharged from the centre in the twelve months prior to the inspection was a serious concern. Five of the children had been discharged due to serious concerns about their behaviour that could not be managed effectively and safely by the staff team.

Of these five children, one was placed in a detention school, one was removed by their social worker following a serious assault, one was removed by a parent due to concerns about his safety, one was placed in an out-of-state specialised therapeutic unit and one was placed in a special care unit. Only one child moved into the local aftercare service in accordance with their care plan.

Of the children placed in the centre at the time of the inspection, one child had been recently removed by their parent after a serious physical assault by another young person. The social worker for another child was actively seeking a private residential centre. Inspectors were told by a social worker that the centre had recently requested supported lodgings for a third child. These are unacceptable outcomes for children. They represent significant instability in individual placements and the function of the centre as a long-term care provision.

The statement of purpose and function states that the management and staff team work to create 'a homely, secure and stable environment for young people'. This was not evident in practice as evidence by the poor outcomes for children and the high number of serious incidents and the levels of risk that they entailed. Senior managers must immediately review this service and ascertain if it is fit for purpose with due regard to the needs of the children being referred to the centre. The review should examine closely the factors that prevent it from functioning as a long-term provision.

Education

Only one child of the five children living in the centre was attending school or training placements consistently at the time of the inspection. Staff members made efforts to encourage young people to attend their schools and training placements but without sustained success. Inspectors were concerned about the poor attendance by the young people in their educational and training placements. This concern was also raised by the HSE monitoring officer in December 2010. The line management should liaise with the centre management and staff team to address this issue in the centre as one child that recently stopped attending school was 14 years of age. Every effort should be made to ensure that children reach their educational potential.

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 children and the manner in which care is provided. The statement is available, accessible and understood.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Purpose and function			√

Recommendation:

1. **The HSENEA should immediately review the functioning of this centre to assess its capacity to provide safe care and good outcomes for children and provide outcome of the review to the Authority.**

2. Management and staffing

Standard
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for children. There are appropriate external management and monitoring arrangements in place.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Management		√	
Register		√	
Notification of significant events	√		
Staffing (including vetting)		√	
Supervision and support		√	
Training and development		√	
Administrative files	√		

Recommendations:

2. **The HSENEA should ensure that external management monitors and supports the work of the manager and staff team to order to improve outcomes for children in the centre.**

3. **The HSENEA should complete a training needs analysis and assess specialist training required**

4. **The HSENEA are required to ensure that the register is maintained in accordance with the regulations.**

5. **The HSENEA should review the practice of staff management and supervision in the centre and ensure that external managers regularly monitor practice and evaluate its effectiveness.**

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.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Monitoring	√		

Recommendation:

6. **The HSE monitoring officer should visit this centre on a regular basis and report to senior managers on findings and progress on specific issues identified in this report and from previous HSE monitoring reports.**

4. Children's rights

Standard
The rights of children are reflected in all centre policies and care practices. Children and their parents are informed of their rights by supervising social workers and centre staff.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Consultation	√		
Complaints	√		
Access to information	√		

5. Planning for young people and young people

Standard
There is a statutory written care plan developed in consultation with parents and children 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 children and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

	Practice met the required standard	***Practice partly met the required standard***	***Practice did not meet the required standard***
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			√
Young people's care records	√		

Recommendations

7. **The HSENEA should review the current admissions risk assessment process to ensure it is robust for the well being and safety of children.**

8. **The HSE NEA should ensure that any placements which end abruptly are reviewed by the Admissions and Discharge panel and any patterns of such discharges are identified and addressed by the HSE.**

9. **The HSE NEA should ensure that, except in an emergency, any decision to change a young person's placement is made within the care review process and in an emergency, soon after.**

10. **The HSENEA should ensure that families are consulted and any concerns about the care of their children are responded to appropriately.**

6. Care of young people

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

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
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 HSENEA should review the assessment and management of risk and the management of behaviour in the centre without delay and put in place effective strategies to address unsafe behaviours by the children.**

12. **The HSE should ensure that absences without authority are appropriately managed and addressed.**

13. **The HSE should arrange for the children in the centre to have access to a computer and to the internet and this access should be managed safely and appropriately in a manner similar to their peers.**

7. Safeguarding and Child Protection

Standard
Attention is paid to keeping children in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Safeguarding and Child protection		√	

Recommendations:

14. **The HSE Dublin North West should ensure that the outstanding child protection notifications are concluded in a timely manner following a co-ordinated response with the relevant agencies.**

15. **The HSE North East should ensure that actions taken by social workers in response to child protection notifications are clearly recorded on the case files and children and families are kept informed of the process and outcome.**

8. Education

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

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Education			√

Recommendation:

16. **The HSE should ensure that all children are in their educational placements or training and that management and staff team are proactive in encouraging their attendance. This should be closely monitored by line management.**

9. Health

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

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Health		√	

Recommendation:

17. The HSE should ensure all children have their medical histories and immunisation records on file.

10. Premises and Safety

Standard
The premises are suitable for the residential care of the children 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.

	Practice met the required standard	*Practice partly met the required standard*	*Practice did not meet the required standard*
Accommodation		√	
Maintenance and repairs	√		
Safety	√		
Fire safety		√	

Recommendations:

18. **The HSE should ensure that the centre manager revises the maintenance register to show clearly the dates when repair works are completed.**

19. **The HSE should arrange for aspects of the physical premises to be upgraded as needed.**

20. **The centre generally should have an up to date health and safety risk assessment in which particular attention should be paid to the structure and use of the laundry.**

21. **The HSE should ensure that external managers regularly assess the physical state and safety of the centre and take appropriate remedial measures.**

22. **The HSE should review the servicing the centre's fire precaution systems and ensure that checks are properly recorded.**

23. **The HSE should arrange for a fire safety officer to assess the centre's fire safety practice in order to raise the manager's and centre staff's awareness of fire safety, and to establish a system of regularly reporting risks to him and keeping a record of any advice received.**

4. Summary of Recommendations:

1. The HSENEA should immediately review the functioning of this centre to assess its capacity to provide safe care and good outcomes for children and provide outcome of the review to the Authority.

2. The HSENEA should ensure that external management monitors and supports the work of the manager and staff team to order to improve outcomes for children in the centre.

3. The HSENEA should complete a training needs analysis and assess specialist training required

4. The HSENEA are required to ensure that the register is maintained in accordance with the regulations.

5. The HSENEA should review the practice of staff management and supervision in the centre and ensure that external managers regularly monitor practice and evaluate its effectiveness.

6. The HSE monitoring officer should visit this centre on a regular basis and report to senior managers on findings and progress on specific issues identified in this report and from previous HSE monitoring reports.

7. The HSENEA should review the current admissions risk assessment process to ensure it is robust for the well being and safety of children.

8. The HSE NEA should ensure that any placements which end abruptly are reviewed by the Admissions and Discharge panel and any patterns of such discharges are identified and addressed by the HSE.

9. The HSE NEA should ensure that, except in an emergency, any decision to change a young person's placement is made within the care review process and in an emergency, soon after.

10. The HSENEA should ensure that families are consulted and any concerns about the care of their children are responded to appropriately.

11. The HSENEA should review the assessment and management of risk and the management of behaviour in the centre without delay and put in place effective strategies to address unsafe behaviours by the children.

12. The HSE should ensure that absences without authority are appropriately managed and addressed.

13. The HSE should arrange for the children in the centre to have access to a computer and to the internet and this access should be managed safely and appropriately in a manner similar to their peers.

14. The HSE Dublin North West should ensure that the outstanding child protection notifications are concluded in a timely manner following a co-ordinated response with the relevant agencies.

15. The HSE North East should ensure that actions taken by social workers in response to child protection notifications are clearly recorded on the case files and children and families are kept informed of the process and outcome.

16. The HSE should ensure that all children are in their educational placements or training and that management and staff team are proactive in encouraging their attendance. This should be closely monitored by line management.

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