



**Health
Information
and Quality
Authority**

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agus Cáilíocht Sláinte

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About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services — Developing person centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Social Services Inspectorate — Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services. Monitoring day and pre-school facilities¹

Monitoring Healthcare Quality — Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services

¹ Not all parts of the relevant legislation, the Health Act 2007, have yet been commenced.

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1. Introduction

The Health Information and Quality Authority's (the Authority) Social Services Inspectorate (SSI) carried out a full inspection of Coovagh House Special Care Unit (SCU) in the Health Service Executive West region (HSE West) under Section 69(2) of the Child Care Act, 1991. This was an announced inspection that took place between 5 and 7 October 2010. SCUs are inspected annually against the Child Care (Special Care) Regulations 2004² and the *National Standards for Special Care* (2001, see Appendix 1)³. Prior to this inspection, the most recent full inspection of the SCU took place in September 2009 (Report ID No. 346) with a follow-up inspection in May 2010 (Report ID No. 398).

At the time of this October 2010 inspection (Report ID 590), Coovagh House accepted referrals from all HSE local health areas. It offered secure residential care for two children of either gender aged between 11 and 17 years inclusively, with capacity for five children in total. Children are detained in a special care unit under a High Court detention order on the basis that they pose a serious risk to themselves or others. Under High Court order, the children's liberty is restricted in order to secure their safety and welfare needs. There are three such units in Ireland, where children can be placed by a National Special Care Admission and Discharge Committee which considers referrals from all 32 local health areas in the HSE.

In Coovagh House, the overall aim is to stabilise high risk behaviour and return the children to an open environment within as short a time as possible. The SCU comprised a unit with living accommodation for up to five children, an administration block, a school, and recreational facilities (including a gym, exercise yard and green area).

Overall, inspectors found that the Unit had gone through a significant period of crisis and there were serious safety concerns in the nine months prior to the inspection. Inspectors found that the Unit had recently regained some stability and shown some improvement after the introduction of an Acting Unit Manager temporarily drafted from another SCU in late August 2010.

Staff interviewed by inspectors were committed to both the children and the recent changes made by the new Acting Unit Manager. However, in the preceding nine months there were significant failings in standards relating to staffing levels, management of behaviour, safety, and governance and management. Inspectors found that staff sickness levels arising from assaults and stress were high, and this impacted on both the care of the children and staff's ability to keep themselves and children safe. The physical structure and fabric of the building and aspects of furnishings such as lighting did not support the effective management of behaviour.

² S.I. 550/2004

³ www.hiqa.ie/functions_ssi_child_standards.asp

Inspectors examined correspondence from internal and external professionals to the National Special Care and High Support Management Team regarding concerns about the safety and welfare of staff and children and found that, in spite of repeated representation of concerns, no effective intervention or supports were put in place to address these until the appointment of the Acting Unit Manager in August 2010. There are several recommendations relating to the issues described above, of which training, a health and safety audit and a maintenance programme require immediate action.

1.1 Methodology

Inspectors' judgments are based on an analysis of findings verified from several sources gathered through a number of means including:

- direct observation
- examination of relevant records
- an inspection of the accommodation
- interviews with two children, the Acting Unit Manager, three social care workers, one social care leader, the HSE Monitoring Officer, the Regional Residential Child Care Manager, the senior psychologist for regional children's residential services, the national manager responsible for special care and a former deputy manager of the SCU. A telephone interview was carried out with a guardian ad litem for one of the children.

Inspectors also had access to the following documents:

- the Unit's statement of purpose and function, policies and procedures
- the Unit's register
- the children's care plans and care files
- summary information on staff
- summary information on children
- administrative records
- staff rosters
- staff supervision and training records
- fire safety compliance documents
- evidence of insurance
- details of unauthorised absences for previous 12 months (11)
- details of physical interventions for the previous 12 months (22)
- details of complaints made by children in the previous 12 months (2)
- details of complaints made by external agents in the previous 12 months (2)
- details of single separation[±] for the previous 12 months (3)
- details of significant incidents for the previous 12 months (139)

[±] Single separation is defined as the isolation of a seriously disruptive young person, for as short a period as possible, to give him/her an opportunity to regain self-control. Source: *National Guidelines on the use of Single Separation in Special Care Unit* (2003)

- questionnaires completed by social workers (2)
- questionnaires completed by guardians ad litem (2)
- one questionnaire completed by a child
- monitoring reports (3).

1.2 Management structure

The Unit was managed by an acting unit manager, a deputy manager and an acting deputy manager. The external management structure, prior to December 2009, consisted of a regional residential child care manager, a child care manager, a general manager and a local health office manager. Management of the SCU transferred to the National Special Care and High Support Management Team at this time and the structures outlined in Chart 1 and Chart 2 demonstrate the management structure prior to and after December 2009.

Chart 1. Management structure of Coovagh House SCU prior to December 2009

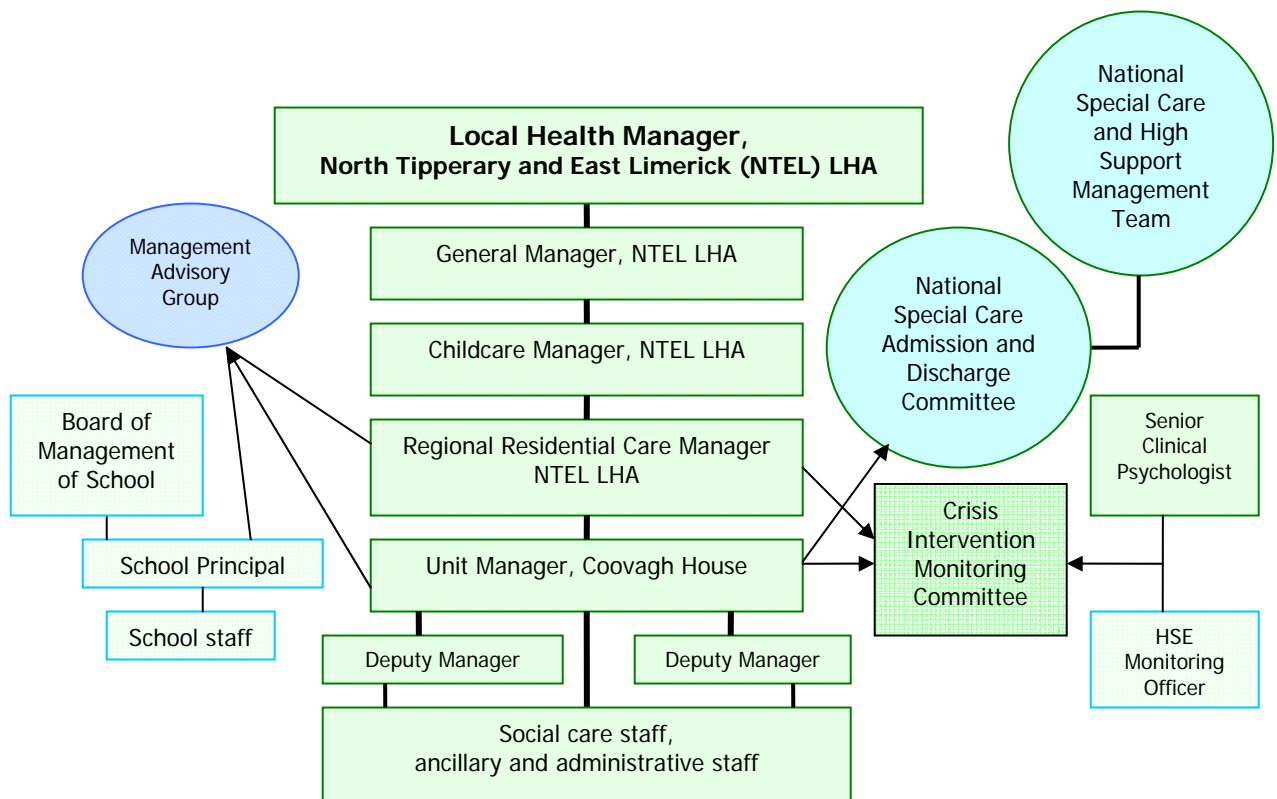
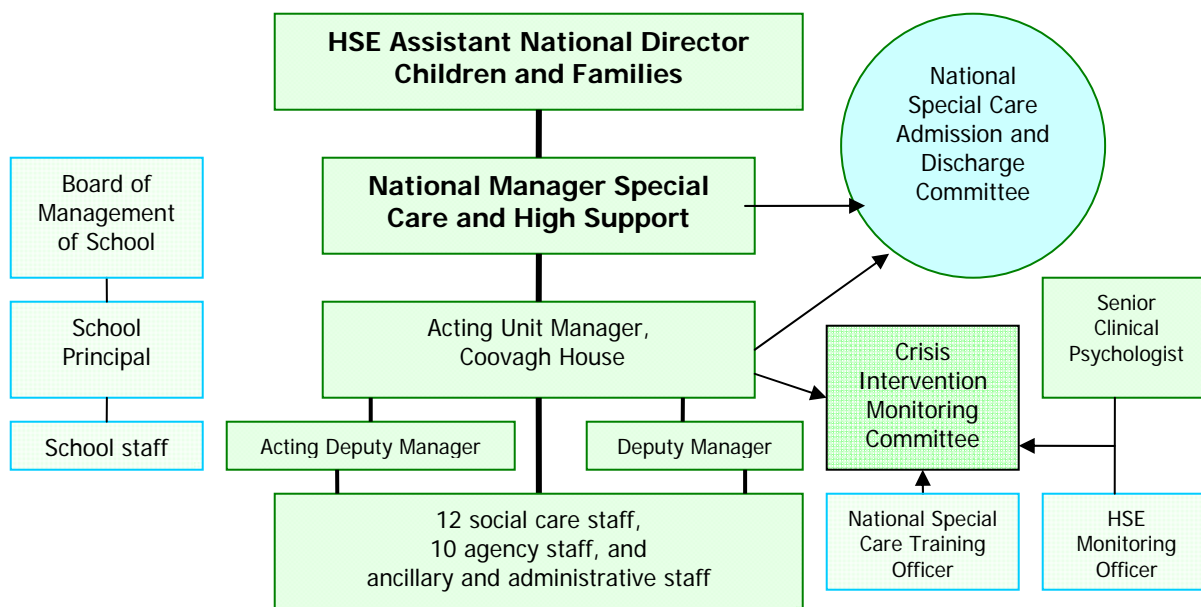


Chart 2. Management structure of Coovagh House SCU October 2010



1.3 Data on children

Inspectors examined the Unit's register and found that in the 12 months since the last inspection there had been five children admitted and three discharged at Coovagh House and that on average there had been two children resident in the Unit at any one time. The average length of placement was four months. Details of the children present in the Unit at the time of the inspection are given in table 1.

Table 1. Children present in the Coovagh House Unit at the time of the inspection

Child	Male/Female	Age	HSE Area which placed the child	Length of Placement	Number of previous placements
# 1	M	16 years 5 months	Dublin Mid-Leinster	6 months	1 residential
# 2	F	16 years 1 months	Dublin Mid-Leinster	4 months 2 weeks	1 residential, 2 foster care placements

Listed in order of length of placement

1.4 Acknowledgements

Inspectors wish to acknowledge the children, staff members and all other professionals who assisted in this inspection.

2. Findings

2.1 Practices that met the required standard

Family contact

There was evidence from interviews and Unit records of regular contact with families and carers as appropriate. Families could visit the Unit and meet the children in private. Staff liaised with families closely around home visits and visits to the Unit. Families also kept in touch through phone calls to and from children which were encouraged by staff and families were informed of significant events.

Legal and court work

Each child's care file had a copy of the High Court detention order. Both children had guardians ad litem. They had frequent contact with the children and attended review meetings. Concerns regarding the safety and wellbeing of the children resident in the Unit had been raised by their guardians ad litem through placement plan reviews and at the High Court sittings. One guardian expressed the view to inspectors that, although staff genuinely wanted to change the crisis-driven practice in the Unit, they were powerless to do so as there was no effective leadership or planning in place. One guardian also stated that for a period of time, the child she represented felt less safe in the Unit than he/she had been prior to coming into secure care.

Leisure activities

The Unit was equipped with a gym which the children used on a regular basis. It had an open space well equipped with climbing apparatus and large enough for playing football. The children were encouraged to pursue their interests and each child had an activity schedule outlining their activities each week. Following a risk assessment, within two weeks after admission, children can go on external outings such as swimming, summer camps, fishing trips, and other activities that interest them.

Single separation

There were three incidents of single separation involving two children since the last inspection in September 2009. Inspectors examined record and care files and found that these separations were appropriate as they were instigated in response to situations where children were at serious risk. The duration of these ranged from 2 to 60 minutes and all were recorded appropriately and notified to the appropriate personnel.

Access to information

The children who spoke to inspectors had a good understanding about accessing information held on the care file. Each file held a confidential section. There was evidence that one child had previously read a daily log. Staff were aware of the children's rights to access information about themselves.

Register

The Unit had a register of children that was maintained on computer with a hard copy kept on file both in the Unit and in an administration office of the HSE. On review of the register, inspectors found that all the details required by the regulations⁴ were recorded, including details of where children were discharged to from the SCU.

2.2 Practices that partly met the required standard

Monitoring

This Standard was met in part. The HSE Monitoring Officer visited on a regular basis⁵ and wrote reports on her findings. Copies of these were submitted to the inspectors. She had highlighted serious concerns regarding safety, management of behaviour, assaults, self-harm of the children, staffing levels and governance and management through her reports and written communication with local and national managers in the year prior to inspection. However, there was evidence that these concerns were not responded to by national managers who were based in the Dublin region. The role of the management team is described further in the Management section of this report. Local managers informed inspectors that they endorsed the Monitoring Officer's views but had no operational management of the Unit. She was also concerned about the number of staff on sick leave owing to work-related stress and the number of agency staff being used – a concern which remained at the time of the inspection.

She was not satisfied that the recommendations in her reports had been addressed or with the delay in some notification of significant events. She confirmed that the situation in the Unit had been unsafe for young people and staff since December 2009. Inspectors examined documentary evidence which supported this view. The current Acting Unit Manager informed inspectors that he was working towards improving the notification of significant events in the Unit. The progress of the Monitoring Officer's recommendations will be assessed at the next inspection.

Notification of significant events

This Standard was met in part. The Unit had a clear system for the notification of significant events but social workers and questionnaires from guardians ad litem stated that some notifications in the last year were not as prompt as required by the regulations.⁶ The Monitoring Officer's reports and her interview with inspectors

⁴ Article 24 (3) of the Child Care (Special Care) Regulations 2004

⁵ Article 22 (1) of the Child Care (Special Care) Regulations 2004

⁶ Article 16 (1) of the Child Care (Special Care) Regulations 2004

confirmed that there had been a difficulty with notifications being delayed. Inspectors recommend that notifications are sent to the relevant personnel promptly, in accordance with the regulations.

Inspectors recommend that the HSE should:

1. Ensure that notifications of significant events are sent to the relevant staff promptly, in accordance with the regulations, and that the appropriate action is taken and the implementation of any actions monitored.

Training and development

This Standard was met in part. Staff training in certain competencies had lapsed and the majority of permanent staff who had trained in therapeutic crisis intervention (TCI) were trained only to a limited level. This meant that they were sufficiently trained only to carry out a standing hold on children and not a team restraint. Article 17(2) of the Child Care (Special Care) Regulations 2004 requires staff in special care units to have appropriate training in the use of physical restraint. Inspectors found clear evidence from the records of incidents and significant events that there were repeated assaults on staff and intimidation of children by peers. It is essential that staff working in an environment where children may engage in challenging and occasionally violent behaviour are trained to intervene fully to prevent a young person from injuring themselves or others.

Since the Acting Unit Manager commenced in post, all staff have received fire safety and child protection (*Children First: National Guidelines for the Protection and Welfare of Children*) training. Inspectors were concerned to find that first-aid training was out of date for many staff, and at the time of the inspection only four staff had an up-to-date first-aid qualification. Given the nature of the secure care service, and this Unit's particular history in terms of episodes of self-harm and violence, it is essential that there are sufficient numbers of staff on duty (including agency staff) who are trained to provide first aid in the event of an emergency.

Inspectors recommend that the HSE should:

2. Complete a training audit of the SCU staff team's training needs.
3. Implement a programme of training suitable to provide safe care to volatile and vulnerable children in a special care environment.
4. Arrange for training for all staff in first aid, therapeutic crisis intervention to an appropriate level, and responding to self-harm, be carried out with immediate effect and ensure that this training is updated and maintained as necessary.

Supervision and support

This Standard was met in part. Supervision had lapsed for some staff during periods of crisis in the Unit. The Acting Unit and Deputy Managers had restructured the supervision system in the weeks prior to the inspection and the Acting Unit Manager stated he met his line manager weekly. Some staff interviewed by inspectors spoke positively about the level of supervision and support offered to them and could identify other internal support mechanisms that had been made available to them. Agency staff were formally supervised by Unit managers and an agency manager. Inspectors recommend that all staff are formally supervised in accordance with Unit policy and the Standards.⁷

Inspectors recommend that the HSE should:

5. Ensure that all staff are formally supervised in accordance with Unit policy and the Standards.

Children's rights – consultation and complaints

These standards were met in part. The child interviewed by inspectors knew how to make a complaint and who to talk to about any concerns or worries. The child informed inspectors that they had confidence that complaints would be resolved satisfactorily. A children's meeting had been held every fortnight and minutes were kept of these meetings. However, in recent months some meetings had not been held. Inspectors were told that children had refused to attend. Any issues raised were brought to the staff meeting the following day to be discussed and feedback was given to the children.

Inspectors examined the complaints register and found that there had been one complaint made by a child in 2010, and an additional complaint was made by a solicitor on behalf of a child. One was dealt with to the satisfaction of the child, and some aspects of the second complaint had been addressed. The Acting Unit Manager explained to inspectors that the outstanding issues relating to the second complaint will not be resolved until the necessary works to reconfigure the layout of the Unit are carried out. Another complaint made by a solicitor who had represented children in the SCU when they appeared in the district court concerned the management of behaviour in the Unit. It was addressed by a member of the National Special Care and High Support Management Team. However, the complainant was not happy with the outcome and indicated that he would take further action. At the time of the inspection this complaint had yet to be resolved. Inspectors found that the system for complaints worked effectively but recommend that formal consultation with children such as children's meetings are promoted and encouraged within the Unit.

⁷ Standard 2.9 of the National Standards for Special Care (2001)

Inspectors recommend that the HSE should:

6. Promote and encourage formal consultation with children such as children's meetings within the Unit.

Primary care – aspects of daily living

Inspectors found evidence of good primary care of the children at the time of the inspection. One child chose not to speak to inspectors. The other child told inspectors that she/he was well cared for and could exercise choice in food, clothing and some leisure activities. He/she could make and receive phone calls in private. He/she could identify individuals on the staff team whom they trusted. This child also commented that since the Unit had gone through a period of crisis and instability he/she felt staff were too guarded in some instances. The child understood the reason for this, but stated: "Staff are too tense; if they relaxed a bit, then so would we."

Staff and children ate meals together and inspectors found that there was flexibility around the serving of meals to involve the children. One child enjoyed cooking with staff and staff were observed engaging positively with both children throughout the inspection. Staff interviewed by inspectors presented as committed to the care of the children.

The daily routine consisted of attendance at the on-site school from 9.40am to 3pm. Break times and lunch were built into this schedule. However, neither child was attending school at the time of the inspection. After school the children had opportunities to have planned outings and activities. Visits from family, social workers and other external professionals were facilitated, as were attendance at various appointments. As the Unit is designed to prevent unauthorised entry or exit, the children's outings were adequately risk assessed and recorded.

The fabric of the Unit had suffered as a result of the challenging behaviour in recent months. There was graffiti on several doors, walls and furniture. Some of this was offensive in nature and all of it should be removed. Some areas were dark with unsuitable fittings, such as loose skirting boards, and would benefit from refurbishment and increased lighting. Within the constraints of safety and security, some parts of the Unit provided a homely atmosphere with ample space for the children to have visits in private. However, inspectors agreed with the view of one child that improvements could be made to soft furnishings (such as curtains in the dining area) to lend a more domestic feel to the Unit. Bedrooms were locked at night.

As described on page 17 in the section on individual care and group living, the Acting Unit Manager separated the two children into separate living areas. He was very concerned that the layout of the Unit was not suited to the control and management of

risk taking behaviours. This separation meant one child had use of the bedroom corridor and other living areas, while the other child was moved to a separate part of the building. A small sitting room was used as this child's bedroom. This gave rise to concerns, as initially there was no bed frame or en-suite toilet/shower available. The child had to ask to be escorted to a nearby toilet, but when that toilet could not be accessed, the child was escorted out of the building to a toilet further away. There was also no storage available for clothes. The facilities within the room have now improved but the arrangement is far from ideal. There was a camera (which was disconnected) and an illuminated fire exit sign (also covered) as the external doors from this room are a fire escape.

The child can now access a bathroom directly opposite the sitting room. Inspectors accept that this arrangement was a response to an unsafe situation and are aware that the children are gradually being reintroduced to each other, with staff strictly monitoring behaviour and interactions. However, it is imperative that the scheduled works are carried out urgently to ensure children have equal access to facilities within the Unit and have a high standard of accommodation and private space.

Inspectors recommend that the HSE should:

7. Carry out the scheduled works to ensure that children have easy access to facilities, that the building is fit for purpose and that the accommodation is maintained at a good standard.

Due consideration must also be given to the child who no longer has access to a bedroom, and staff should ensure their dignity and privacy is promoted and upheld at all times. Inspectors' recommendations relating to the physical condition of the building are detailed in the section on premises, safety and security on page 23.

Referral and placement of children

All referrals to special care units come through the High Court which considers an application for a detention order after a referral has been processed by the National Special Care Admission and Discharge Committee. The Acting Unit Manager is a member of this Committee but had not attended in the weeks prior to the inspection as the SCU was not taking referrals. The National Manager Special Care and High Support informed inspectors that no further placements would be offered by the SCU until the necessary building works were undertaken.

Education

The Standard on education was met in part. The Unit had access to an on-site school which operated under the Department of Education and Skills. It had its own board of management which met on a monthly basis. The school provided education to children from other services within the HSE region, which provided good opportunities for

learning through socialisation. One child had not attended school since admission due to emotional difficulties. The Acting Unit Manager informed inspectors that this issue was being treated effectively and that the child was working towards attending school. The other child had attended school daily for a while but had withdrawn temporarily at the time of the inspection. Appropriate steps were taken by the school, to address the problems of non-attendance.

In general, the children had experienced disruption in their overall education, and had not attended school on a regular basis prior to their admission. The disruptions in their care within the SCU had not created an environment in which they could feel secure about attending school.

Inspectors recommend that the HSE should:

8. Ensure that every effort is made to engage and encourage all children in the Unit to attend school.

Purpose and function

The Unit had a written statement of purpose and function that defined its role within the national child care service and set out the manner in which care was provided to children. The day-to-day practice observed and evidenced through interviews was reflected in the statement. The Acting Unit Manager told inspectors that a model of care had still not been developed and agreed which could be referenced in the Unit's statement of purpose and function. This issue was identified at the last inspection in September 2009 and inspectors again recommend that the draft model of care is agreed and approved by HSE senior management without further delay. Once this has been done it should be reflected in the Unit's policies and practices.

Administrative and care files

Overall, the recording systems that operated in the Unit were of a good quality. Care files were organised and well structured. However, inspectors found some omissions and incomplete records in the maintenance and fire logs.

Inspectors recommend that the HSE should:

9. Ensure that all records are kept up-to-date and complete, and that Unit managers monitor records regularly to identify any omissions.

Staffing

At the time of the inspection, the Unit employed a total of 31 whole-time equivalent posts filled by:

- one Acting Unit Manager
- one Deputy Manager
- one Acting Deputy Manager
- two social care leaders
- 22 social care workers (including 10 agency workers)
- one chef post (*filled by two part-time staff*)
- one housekeeping post (*filled by two part-time staff*)
- one clerical staff.

Of the 22 social care workers and two social care leaders, seven were on sick leave or unable to undertake direct work with children. Ten agency staff were employed to cover staff on long-term sick leave and staff who were confined to office work due to medical conditions or pregnancy.

The majority of permanent HSE staff were suitably qualified and well experienced. However, several of them were on sick leave or unable to carry out direct work with children. In correspondence to the National Special Care and High Support Management Team, the local Regional Occupational Health Department expressed concern about the number of staff who had been referred to it owing to stress or following assaults. The Occupational Health Department requested that some staff should be redeployed given that they were deemed unfit to work in the SCU. However, given that the management of the SCU was transferred to the National Management Team, there is a lack of clarity as to how and where these staff can be deployed. Inspectors were told that opportunities to transfer to local children's residential centres would not be available for these staff. Inspectors recommend this issue is addressed immediately to expedite a more permanent staffing solution for the SCU.

Agency staff had less experience than the HSE staff group, and for many this placement was their first experience of secure care.

Both staff and the Monitoring Officer told inspectors that in the nine months prior to the inspection, permanent staff were frequently outnumbered by agency staff on shift and this contributed to the lack of cohesive practices in the Unit. Interviews with staff and other professionals and examination of records of incidents in the Unit showed that staff confidence had been eroded over the last year and all staff were increasingly stressed.

This was due to a variety of factors including: serious assaults on staff, poor management of behaviour, severely depleted staffing and management levels and a lack of suitable training for staff. Children did not feel safe in the Unit and presented as extremely challenging and engaged in serious risk-taking behaviour. Staff were not trained to carry out full restraints on children and many minor disagreements escalated into serious events.

Previous unit managers were on sick leave since mid year, and an additional young person was admitted, increasing the strain on the depleted staff group. At times where staffing numbers were reduced, staff retreated to a unit office to monitor children via closed circuit television (CCTV) cameras. Inspectors were told that on several occasions it was necessary to call on the Garda Síochána to assist staff in maintaining good order for children, particularly at bedtime. This was subject of a recommendation of the 2009 inspection report. (This is referred to in the section on promoting good order on page 18.) There were incidents of serious self-harm by children, yet only four staff had up-to-date first-aid training.

One such incident culminated in a major crisis in the management of the Unit when the majority of staff took sick leave over one weekend in June 2010. On 14 July 2010, inspectors asked the National Management Team to review this incident. However, the review has yet to be concluded. Inspectors recommend that this review be completed as a matter of urgency.

Inspectors recommend that the HSE should:

10. Ensure that the review into staffing deficits in the Unit in June 2010 be completed.

Overall, given the difficulties with leadership and staffing as described to the inspectors, there were not enough permanent staff with the appropriate specialist training (such as full therapeutic crisis intervention (TCI), responding to self-harm, and first aid) to manage behaviour and run the Unit consistently and safely.

Inspectors examined the staff roster which ran over a 16-week cycle. The Acting Unit Manager had increased staffing numbers in the month prior to the inspection. Four staff worked from 8.30am to 9pm and four staff from 2pm to 10pm. Three waking night staff came on duty at 9pm. Standard 2.15 requires that the number of staff on duty at any time is sufficient to promote the children's welfare and to maintain their safety and security.

A sample of permanent staff files were read and found to be of a good standard with appropriate vetting carried out prior to the employment. Also, 50% of agency staff personnel records were examined by inspectors and found to have the necessary checks and clearances.

At the time of the inspection, the Unit, which had a potential operating capacity for five placements, was not operating to full capacity. Previous inspection reports have highlighted the fact that the Unit has never operated to full capacity. Inspectors were told by the Acting Unit Manager and the National Manager that this was due to staffing

shortages and the safety issues described in this report. The National Manager advised inspectors that increased placements will not be considered until the necessary building works are undertaken in the Unit to allow additional children to be accommodated safely.

Inspectors recommend that the HSE should:

11. Address the long-standing staffing difficulties encountered in the Unit to adhere with regulations.⁸
12. Address the reduced capacity of the Unit considering the needs for placements from a national perspective.
13. Review and develop the behaviour management policies and practices of the Unit including the use of Garda Síochána.

Emotional and specialist support

The Unit had good policies and procedures in relation to emotional and specialist supports. It also had the services of a senior clinical psychologist for children's residential services in the region, who had time dedicated to the SCU. He attended staff meetings and supported key workers. He undertook direct work with both children. Those interviewed spoke positively of his involvement and the ease of accessibility to him for clarity in relation to work with individual children.

Access to external services was maintained and facilitated where possible. Inspectors found evidence that children had access to psychiatric services where required.

Inspectors were very concerned about the number and gravity of some episodes of self-harm by children. In one incident, it took three staff some time to remove a ligature that could have been removed swiftly with the correct equipment (a Hoffman knife). Inspectors were informed that the correct equipment is now held in the Unit, and recommend that staff receive appropriate training in responding to self-harm, first aid, and the use of specialised equipment. (See earlier section on training and development and Recommendation 4.)

Individual care in group living

At the time of the inspection, both children were living separately within the Unit. The Acting Unit Manager explained to inspectors that it was necessary to separate the children for a period of time when he commenced in post, as the situation in the Unit was unsafe. Both children were engaging in high risk behaviour and the physical layout of the Unit made it impossible to supervise them and manage behaviour effectively.

⁸ Article 5 of the Child Care (Special Care) Regulations 2004

(This is described in further detail below in the section on accommodation and promoting good order.)

Each child had a case manager who was a social care leader and two key workers. Key worker sessions were recorded in the daily log book and in a key worker communications book. In an interview, inspectors were told that one child had only one key worker for a period of time due to staff shortages. The Acting Unit Manager informed inspectors that he was addressing this issue.

Another child had begun to engage more with staff since the Acting Unit Manager commenced in post, and had begun to interact and socialise more positively than previously. Staff informed inspectors that they felt more secure and confident in caring for children in recent weeks and felt that while separating the children was not ideal, it had a positive impact on children's behaviour and wellbeing.

Use of physical restraint

As indicated previously, the Unit staff were not fully trained in TCI. The Unit had also developed a strategy for responding to the personal alarm system installed in the Unit and carried by all staff, should an incident occur. Records provided to inspectors showed there were 23 physical interventions since the last inspection. As the majority of staff were not fully trained to carry out team restraints, most interventions by staff consisted of protective blocking and standing holds. In some incidences these interventions were not effective and the incidents escalated. On 28 occasions when incidents escalated, the Garda Síochána was called to intervene or control the situation. (See section on staffing on page 16 and promoting good order below.)

Promoting good order

On review of the sanctions register, daily logs and incident reports, inspectors were concerned that the management of behaviour had deteriorated significantly from the time of the last inspection. As outlined above in the section on the use of physical restraint, records provided to inspectors showed that on 28 occasions it was necessary to call on the Garda Síochána to assist staff with children.

The incident log showed there were 139 incidents since the last inspection. Forty-nine of these were assaults on staff. There were seven assaults on other children. On four occasions, children gained access to staff keys and also gained access to items which were used as weapons. Staff and other professionals told inspectors that the Garda Síochána were called to deal with escalating behaviours so as to ensure safety and to prevent charges of assault and criminal damage. Inspectors also found the Garda Síochána was called to help get children to go to their bedrooms at night.

Several professionals interviewed described the SCU as unsafe for children and staff. As stated previously, these and other professionals associated with the Unit wrote to the National Management Team responsible for special care describing the crisis within the

Unit and their grave concerns regarding safety, but these concerns were not addressed until the Acting Unit Manager commenced in post, and some correspondence, dated over several months, had not received a reply at the time of the inspection. Due to the combined effect of a lack of leadership, depleted staffing numbers, lack of appropriate training and increased challenging and violent behaviour, staff did not have the capacity to manage these behaviours safely.

Inspectors found that the management of behaviour had improved significantly in the weeks prior to the inspection and they were satisfied that the Acting Unit Manager and staff were committed to this improvement.

Inspectors recommend that the HSE should:

14. Give due regard to the safety of children and staff and the rights of the children in the Unit.

Safeguarding and child protection

The Unit did not have a safeguarding policy incorporating accepted safe care practices. This is an outstanding recommendation from the last inspection. In the 12 months prior to the inspection there had been two child protection notifications which were notified to the appropriate personnel. The Unit had a comprehensive child protection policy which included a section on inter-area protocols regarding child protection notifications. This was commendable.

Inspectors recommend that the HSE should:

15. Develop a safeguarding policy, as required by Standard 5.1, and provide guidance and training in safeguarding practice.

Care plans and reviews

The Standard on care planning and statutory care plan reviews was partly met. Care plans viewed by the inspectors were of a good quality. Reviews were carried out frequently and children attended these. Care files showed that the children were prepared for their reviews and completed a report for the process.

Both children were 16 years of age but did not have aftercare plans in place. The child interviewed had a good understanding of the reason for being in special care but was concerned about the future, and staff confirmed that no onward placement has yet been identified for this child.

Inspectors recommend that the HSE should:

16. Develop aftercare plans for both children and onward placement plans should be discussed with the children in a timely manner.

Social work role

Each of the children had an assigned social worker. In the 12 months prior to this inspection the majority of children placed in Coovagh House were from Dublin and one was from the southeast region. Social workers visited the children in accordance with the statutory requirements and statutory review meetings took place in accordance with the regulations. As the Unit is a national resource, children can be placed from any geographical region in the country. Inspectors found that outside of monthly reviews held in the Unit, social workers visited the children currently placed in the Unit fortnightly in accordance with the Standards.⁹

Both social workers completed questionnaires and said that changes in staffing had made communication difficult at times. However, one social worker acknowledged that staff had shown a commitment to the child. The Acting Unit Manager confirmed there had been a lack of structure in communication with social workers prior to his appointment but he had put measures in place to address this. There was evidence that at least one social worker had read the Unit's log books and files. Social workers were reported to meet children in private in addition to their attendance at reviews. Inspectors suggest that all supervising social workers read Unit logs and files from time to time.

Health

The children had medical assessments on admission. They had access to dental, optical and other health services as required. Inspectors were concerned that there were no comprehensive medical histories on file for the children as required by Standard 5.19. The Unit log required two signatures when dispensing medication and records seen were complete. One child told inspectors that staff had delayed a request made to see the general practitioner (GP) as they felt the appointment was not necessary. The child stated this had been resolved by the Acting Unit Manager. Inspectors spoke to the Acting Unit Manager who said that all staff have been advised to respond positively and promptly to requests by children to see their GP.

Inspectors recommend that the HSE should:

17. Ensure that on admission a detailed comprehensive medical history is provided by placing social workers to the Unit.

⁹ Standard 4.22 of the National Standards for Special Care (2001)

18. Ensure that children who request to see or speak to their doctor are supported to do this promptly.

2.3 Practices that did not meet the required standard

Management

The Standard on management was not met. This inspection found that, whilst managers interviewed were by and large clear about personal accountability and responsibility within their control, services functioned separately with no tangible evidence of strategic direction.

Overall management of the Unit passed from the regional management structure to the National Special Care and High Support Management Team in late December 2009. The creation of a national management structure was designed to coordinate special care as a national resource. This coincided with an increase in staff sick leave and the admission of a child whose behaviour was complex and extremely challenging. Staff and external professionals informed inspectors that lines of accountability were unclear from this point, and that they had not received responses from national managers to concerns they had raised in the following months. Communication between operational and national management was not effective as it yielded no change to the deterioration of good order in the Unit. The management of challenging behaviour, risk, and serious incidents was poor, staff sick leave and assaults increased and the previous unit manager and a deputy also went on sick leave in mid 2010.

The remaining deputy was left in charge in the Unit with increasing numbers of agency staff. A significant number of staff were on sick leave as a result of either injuries received from being assaulted, or stress, or being unfit to work in the Unit due to medical conditions. The remaining deputy returned to her substantive post in residential childcare, and the Unit was left without a manager until the current Acting Unit Manager and an acting deputy were brought in from another unit.

The previous regional structure, as shown in Chart 1 on page 5, and the attendant supports, such as the management advisory committee, were no longer available as the service was being managed nationally. Overall, serious difficulties of leadership impacted negatively in the Unit and presented itself as a crisis of confidence and authority which manifested itself particularly in the management of the challenging and high risk behaviour.

The previous unit manager has since transferred to a different role on the National Special Care and High Support Management Team and the remaining deputy returned to work in the Unit on the second day of this inspection. Inspectors examined copies of a range of correspondence raising concerns about the service, which were sent to the

National Management Team from the monitor of the Unit, the local health manager, the senior clinical psychologist attached to the Unit, the regional HSE occupational health consultant, the former deputy manager of the Unit and the children's solicitors. This correspondence dated from January 2010 to the time of this inspection and detailed the serious concerns of these professionals regarding the safety of children and staff, the crisis in staffing numbers and availability, and the lack of leadership and support available to children and staff.

The correspondence reflected the fact that the authors' concerns were not being addressed and that the Unit was in crisis. Members of the National Management Team visited the Unit sporadically, and unit managers were on sick leave. Consequently, staff felt isolated and unsupported, and the Unit lacked clear leadership.

In interview with the inspectors, the new Acting Unit Manager said that the operation of the Unit was unsafe when he commenced in post. He had introduced several new practices which are described in detail in this report and staff informed inspectors these changes had improved the safety and wellbeing of children and staff.

Staff and a guardian ad litem told inspectors that the Acting Unit Manager had provided clear leadership and was supportive and worked directly with children on a daily basis. One child told inspectors they felt 'safer' since the Acting Unit Manager had commenced in post. Inspectors saw evidence of the improvements and guidance provided, but were informed that the acting post remains a temporary and a short-term response to the crisis. This does not provide the stability required for children and staff in the long term.

Inspectors found evidence of sporadic monitoring of Unit records by Unit management and social care leaders. The Unit had developed comprehensive policy and procedure documents which guided care practices and the rules of the Unit, but some practices had not concurred with policy during periods of crisis.

Inspectors recommend that the HSE should:

19. Ensure the post of Acting Unit Manager should be substantiated or confirmed on a longer-term basis and relevant associated issues regarding terms and conditions should be addressed as a matter of urgency.
20. Develop a coherent recovery plan to enable the Unit to move on from the previous period of crisis and regain the ability to function effectively as a national resource. The plan should incorporate arrangements regarding governance, leadership, management, staffing, safety and the physical structure of the Unit.
21. Address the temporary status of the Unit's management in order to provide long-

term stability and leadership.

22. Develop an agreed strategy, consistent with the national strategy for the special care service, to address any future leadership and management deficiencies.

Premises, safety and security

Overall, the condition of the building had deteriorated since the last inspection. Communal areas were poorly lit, shabby and showing significant signs of wear and tear. In some cases this impacted directly on safety. There had been significant property damage since the previous inspection in September 2009, including damage to fire doors and bedroom locks. As described previously, there was graffiti on several surfaces, some of which were offensive. Inspectors found no record of maintenance requests to remove graffiti.

In practice many repairs were temporary and unsightly, for example pieces of wood were used to cover windows/panels and door frames. Inspectors were very concerned to find some repairs had not been attended to in several months. In one instance, a piece of skirting board that was identified as needing repair in March 2010 was used as a weapon to assault a staff member in May 2010. Records showed that the skirting board had still not been repaired satisfactorily.

Inspectors found that some maintenance requests were repeatedly referred to the relevant HSE maintenance department with no subsequent action. Inspectors were also concerned to discover repeated requests to the same department about malfunctioning locks. The pin point system that staff used to summon help in the event of a crisis was also prone to failing at times. Inspectors were informed that when fluorescent lighting bulbs were due to expire, the operation of the pin point system would fail. In one instance this occurred when a staff member was being assaulted. All of these issues added to the deterioration in good order in the Unit and the staff's ability to keep children and themselves safe.

Given the deficiencies in safety described above, inspectors were very concerned that no health and safety audit had been carried out in the Unit since mid 2009.

As described previously in this report, correspondence from the region's occupational health unit to the National Management Team also clearly outlined the Unit's failings regarding the health and safety of staff from assaults, staff absences and staff being medically unfit to work in the Unit.

The Unit had all the relevant documentation required by the regulations including insurance and written confirmation of fire safety and building control compliance. Fire extinguishers and blankets were checked on an annual basis, the last check being in October 2010. There were seven fire drills in the nine months prior to the inspection,

but on four occasions one child refused to comply with the drills and evacuate the building. Systematic security checks were carried out by a security firm that was situated at the main reception area to the Unit.

Inspectors recommend that the HSE should:

23. Develop a strategy for dealing with non-compliance with evacuation procedures.
24. Ensure that all children evacuate the Unit during drills and any child's non-compliance with evacuation procedures should be notified as a significant event to all who are concerned with that child's case.
25. Carry out a risk assessments on the effectiveness of the pin point system and the quality and suitability of the Unit's locks.
26. Carry out a health and safety audit immediately, incorporating the potential for self-harm, personal safety of staff and children and the availability of potential weapons in the Unit.
27. Ensure a rolling programme of maintenance should be put in place urgently to ensure that all outstanding maintenance requests are addressed and future requests are responded to in a timely manner.
28. Implement a system to regularly monitor maintenance requests and implement actions immediately and all graffiti should be removed from furniture, fixtures and surfaces.
29. Carry out a risk assessment on all staff who are unable to work directly with children due to injury or medical conditions.

3. Summary of recommendations

The HSE should:

1. Ensure that notifications of significant events are sent to the relevant staff promptly, in accordance with the regulations, and that the appropriate action is taken and the implementation of any actions monitored.
2. Complete a training audit of the SCU staff team's training needs
3. Implement a programme of training suitable to provide safe care to volatile and vulnerable children in a special care environment.
4. Arrange for training for all staff in first aid, therapeutic crisis intervention to an appropriate level, and responding to self-harm, be carried out with immediate effect and ensure that this training is updated and maintained as necessary.
5. Ensure that all staff are formally supervised in accordance with Unit policy and the Standards.
6. Promote and encourage formal consultation with children such as children's meetings within the Unit.
7. Carry out the scheduled works to ensure that children have easy access to facilities, that the building is fit for purpose and that the accommodation is maintained at a good standard.
8. Ensure that every effort is made to engage and encourage all children in the Unit to attend school.
9. Ensure that all records are kept up-to-date and complete, and that Unit managers monitor records regularly to identify any omissions.
10. Ensure that the review into staffing deficits in the Unit in June 2010 be completed.
11. Address the long-standing staffing difficulties encountered in the Unit to adhere with regulations.
12. Address the reduced capacity of the Unit considering the needs for placements from a national perspective.
13. Review and develop the behaviour management policies and practices of the Unit including the use of Garda Síochána

14. Give due regard to the safety of children and staff and the rights of the children in the Unit
15. Develop a safeguarding policy, as required by Standard 5.1, and provide guidance and training in safeguarding practice
16. Develop aftercare plans for both children and onward placement plans should be discussed with the children in a timely manner.
17. Ensure that on admission a detailed comprehensive medical history is provided by placing social workers to the Unit.
18. Ensure that children who request to see or speak to their doctor are supported to do this promptly.
19. Ensure the post of Acting Unit Manager should be substantiated or confirmed on a longer-term basis and relevant associated issues regarding terms and conditions should be addressed as a matter of urgency
20. Develop a coherent recovery plan to enable the Unit to move on from the previous period of crisis and regain the ability to function effectively as a national resource. The plan should incorporate arrangements regarding governance, leadership, management, staffing, safety and the physical structure of the Unit.
21. Address the temporary status of the Unit's management in order to provide long-term stability and leadership.
22. Develop an agreed strategy, consistent with the national strategy for the special care service, to address any future leadership and management deficiencies.
23. Develop a strategy for dealing with non-compliance with evacuation procedures.
24. Ensure that all children evacuate the Unit during drills and any child's non-compliance with evacuation procedures should be notified as a significant event to all who are concerned with that child's case
25. Carry out a risk assessments on the effectiveness of the pin point system and the quality and suitability of the Unit's locks.
26. Undertake a health and safety audit immediately, incorporating the potential for self-harm, personal safety of staff and children and the availability of potential weapons in the Unit.

27. Develop a rolling programme of maintenance should be put in place urgently to ensure that all outstanding maintenance requests are addressed and future requests are responded to in a timely manner.
28. Implement a system to regularly monitor maintenance requests and implement actions immediately and all graffiti should be removed from furniture, fixtures and surfaces.
29. Carry out a risk assessment on all staff who are unable to work directly with children due to injury or medical conditions.

4. Conclusions

The inspection found that some of the *National Standards for Special Care* (2001) were met and found evidence of good practice in the care of the children. There was also evidence of child-centred culture and practice. However, inspectors had serious concerns in relation to self-harm, safe care, the management of challenging behaviour, and governance of the Unit.

A key area of concern for inspectors related to the sustainability of the temporary management arrangements in place since August 2010. The HSE immediately responded to this recommendation and a temporary deputy manager was appointed.

The governance of this Special Care Unit, in the context of the national special care services, is of utmost concern to the Authority. The planned transfer of the management and operational responsibility of Coovagh House from the National Special Care and High Support Management Team to centralised HSE management under the umbrella of the Regional Director of Operations Dublin North East has not occurred. There is no clear evidence of a national strategy for special care services and no one person in charge of the special care units. The capacity and responsibility of the management team in the HSE West to make decisions pertaining to the management of the Unit is unclear and this makes the current arrangement unsafe.

Coovagh House is a national resource, where children from all 32 local health areas in the HSE can be placed by a National Special Care Admission and Discharge Committee. It has a capacity of five places. Inspectors found the Unit was under utilised and there were significant period of crisis in the Unit. There were serious safety concerns in the nine months prior to the inspection. However, the Unit had recently regained some stability and shown some improvement after the introduction of an Acting Unit Manager. There were concerns about staffing levels, which impacted on the safe care of children in the Unit. The physical structure and fabric of the building and aspects of furnishings such as lighting did not support the effective management of behaviour.

The Authority was informed that the National Special Care and High Support Management Team was aware of the concerns about the safety and welfare of staff and children. However, the Authority found that, in spite of repeated representation of concerns, no effective intervention or supports were put in place to address these until the appointment of the Acting Unit Manager in August 2010.

5. Next steps

The Authority has undertaken coordinated and simultaneous inspections of all three Special Care Units in Ireland which form the national special care service. In conjunction with the inspection reports of the three Units, the Authority has published an overview of the special care services in Ireland, *National Overview Report of Special Care Services provided by the Health Service Executive* (Report ID Number 592). Therefore, this report should be read in conjunction with the two other inspection reports: Gleann Alainn Special Care Unit (Report ID No. 589) and Ballydowd Special Care Unit (Report ID No. 591) and the Overview Report. These reports are on the Authority's website, www.hiqa.ie.

This full inspection of Coovagh House Special Care Unit informs the Authority's national Overview Report on special care services provided by the HSE. The Overview Report considers key themes identified during the inspections of the three Special Care Units and will inform the Authority on the recommendations which will be specific to the national special care services. The national recommendations contained in this Overview Report will be directed at the HSE.

The completed reports on all inspections by the Authority of the three Units and the Overview Report will be issued to the Minister for Health and Children and to the Minister for Children and Youth Affairs. The Authority will request an action plan on all of the recommendations contained within these reports from the HSE within 10 days of their publication. The Authority will also request a monthly progress report on the implementation of these HSE actions.

The Authority will again report to the Minister for Health and Children within three months of publication of these reports on the status of the implementation of the Authority's recommendations and the resulting HSE action plans.

Appendices

Appendix 1

National Standards for Special Care (2001)

Standard 1. Purpose and function

The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for children and the manner in which care is provided. The statement is available, accessible and understood. The unit's role in relation to the wider child care services (including regional and national) is clearly set out by the Health Service Executive.

Standard 2. Management and staffing

There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and meet the needs of the children. The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.

Standard 3. Monitoring

The Health Service Executive has adequate arrangements in place to enable an authorised person, on behalf of the Health Service Executive to monitor statutory and non-statutory children's residential centres.

Standard 4. Planning for young people

There is a written care plan to promote the welfare of each young person which is subject to regular review. This stresses and practically supports contact with families, preparation for adulthood, promotes education and health needs and addresses the emotional and psychological needs of the children.

Standard 5. Care of young people

Children are cared for by staff who can relate effectively to them. Day-to-day care is of good quality and provided in a way which takes account of their individual needs in relation to age, race, culture, religion, gender and disability. Children are cared for in a manner which safeguards and actively promotes their legal and civil rights. Children whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the Health Service Executive.

Standard 6. Premises, safety and security

The premises and associated outdoor areas are designed to prevent unauthorised entry or exit. They should facilitate supervision and minimise opportunities for self-harm while providing accommodation which is, in so far as practicable, appropriate to its designation as a children's home. It must also be properly maintained and furnished.

Standard 7. Education

Education should be seen as an integral part of the care of the young person. The education of all children should be actively promoted by all involved. In so far as it is practicable, units should aim to provide for those of school age, a broad and balanced curriculum appropriate to their age, ability and level of attainment with a view to continuing in open conditions or a return to mainstream school. Where appropriate, children over the age of 16 should be offered a programme where vocational preparation, training and work experience or transition to further education.