



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Ballydowd Special Care Unit in the Health Service Executive Dublin Mid-Leinster

Action plan

Inspection report ID number: 591

Fieldwork date: 27 October 2010

Publication date: 15 December 2010

SSI Inspection period: 12

Unit ID number: 101

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.

Contents

1. Introduction	4
2. Findings	4
3. Conclusions	12
5. Next steps	12

1. Introduction

The Health Information and Quality Authority's (the Authority) Social Services Inspectorate (SSI) carried out an announced follow-up inspection under *Section 69(2) of the Child Care Act, 1991* of Ballydowd Special Care Unit (SCU1) in the Health Service Executive (HSE), Dublin Mid-Leinster (HSE DML) which also includes the Solas Unit (SCU2), located in a high support campus in the Dublin North East region (DNE). SCU2 was designated as a special care facility in agreement with the High Court for three children following a fire incident in the SCU1 campus on 25 October 2009.

This follow-up inspection was carried out on 27 October 2010. The purpose of this inspection (Inspection report ID No. 591) was to assess compliance of the local HSE action plan response to the recommendations made at the last full inspection by the Authority in July 2010 (Inspection report ID No. 410).

The Acting Director of Ballydowd SCU had responsibility for both Units (SCU1 and SCU2) at the time of this inspection. Inspectors did not visit the Solas unit (SCU2) during this follow-up inspection.

2. Findings

At the time of this inspection, there were seven children resident in the two Units, four boys and one girl aged 13 to 16 years in SCU1 and two girls aged 13 to 15 years in SCU2. Since the inspection in July 2010, there have been four new children admitted to SCU1 and one child discharged from SCU2.

Nineteen recommendations had been made following the inspection fieldwork on 1, 2 and 8 July 2010. The inspectors found that 12 recommendations had been met, five were met in part and two recommendations were not met. Inspectors continued to be concerned that children were still residing in a unit (SCU2) that was not fit for purpose, pending the refurbishment of a unit in SCU1.

The inspectors interviewed the National Specialist for Children and Families with line management responsibility for special care and high support, the Acting Director of SCU1 and SCU2 and the monitoring officer during the follow-up inspection. They also met with the young people and staff in the Unit as well as two clinical practitioners who were visiting the Unit on the day. The inspectors examined relevant records and documentation.

The findings of this follow-up inspection are presented in the form of a table which addresses each recommendation, the action to be taken by and by whom. The table also outlines the original timeline that the HSE proposed in order to implement each of the recommendations. Table 1 contains the action plan and findings of the follow-up inspection relevant to each recommendation from the full inspection. It also contains the HSE actions to be taken where a recommendation was found by inspectors to have been met in part or not met.

Table 1. Social Services Inspectorate Action Plan for Inspection No. 410, Ballydowd Special Care Unit

Centre ID:	101	Date Action Plan dispatched:	24 August 2010
HSE Area:	HSE Dublin Mid-Leinster	Date Action Plan updated:	27 October 2010

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
1	The use of the current units at Ballydowd and Solas as special care facilities ceases with immediate effect and children are not placed in them until they are completely brought up to standard.	<p>Refurbishment and repairs to BSCU Unit 2 completed by Mid September 2010.</p> <p>Refurbishment to BSCU Unit 3 to be completed by third to fourth week October 2010.</p> <p>Solas Unit to close following discharge of last young person; no new admissions.</p>	National Manager Special Care and High Support and Team.	October/ November 2010.	<p>Recommendation not met.</p> <p>Inspectors were informed that there had been a significant increase (50%) in demand for special care placements in 2010. Subsequently, the HSE stated that it was not possible to close Ballydowd (SCU1) and continued to keep both SCU1 and Solas Unit (SCU2) open pending a new national model of special care and high support provision.</p> <p>The interim plan was for SCU1 to remain open. SCU2 was due to close following the discharge of the last child which was proposed for December 2010/January 2011. Notwithstanding the demand for placements and the refurbishment being carried out to ensure the Unit is fit for purpose, inspectors were still concerned that children</p>

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
					were residing in a unit (SCU2) that was not fit for purpose. The proposed date for the refurbished unit in SCU 1 was January 2011.
2	The scope and limitations of Ballydowd's therapeutic provision are clearly explained to referring social workers.	Letter to be issued with letter of acceptance for referrals	Director BSCU	Immediate	Recommendation met. Inspectors were shown details of statement to be included in letters of acceptance to social workers.
3	Managers provide training in <i>Children First: National Guidelines for the Protection and Welfare of Children</i> for care staff who have not received it.	Training Officer has organised two training days, to cover staff not yet trained,	Director BSCU, Training Officer		Recommendation met. Training was provided between 5 and 19 October 2010.
4	There are safer, suitable options compliant with regulations, standards and inspection	The National Special Care Admissions and Discharge Committee can only place children in the designated centres. Works on schedule as	Chair, National Special Care Admissions and	Ongoing	Recommendation met in part. Interim arrangements for special care provision were addressing some of the identified needs. This will be assessed further in the first

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
	recommendations available to the admissions committee when processing referral applications.	above. Chair will liaise with referring social worker and feedback views of committee.	Discharge Committee		quarter of 2011.
5	One accountable HSE monitoring officer is appointed with clear terms of reference and lines of reporting.	Appointment of Monitoring Officer subject to establishing whole time equivalent	Regional Director of Operations, DNE and National Manager of Special Care and High Support		Recommendation not met. Both SCU1 and SCU2 had a monitoring officer by private arrangement who was not a HSE employee. Inspectors were informed that this arrangement was due to cease. No timeframe was provided for this post of monitoring officer to be filled. The monitoring function for such a transient population of extremely vulnerable and at times volatile children should be strengthened. The recommendation still stands and should be dealt with as a matter of priority.
6	Visits to the SCUs should be carried out by the monitoring officer under Section 22 of the Child Care (Special Care) Regulations 2004.	Completed	National Manager SC and HS and Team	Completed	Recommendation met. This was carried out by the independent monitoring officer

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
7	Rigorous follow-up on the full implementation of the outstanding recommendations of the SSI reports are carried out by the HSE monitoring officer.	National Manager to write to monitoring officer	National Manager	September 2010	Recommendation met. This was carried out by the independent monitoring officer
8	A review of cases/placements should be carried out by a competent person independent of the line management structure.	Weekly review carried out of SCU population by project team. Suitable person outside of line management being identified	National Manager SC and HS and Team	October 2010	Recommendation met in part. Inspectors were informed that there were no resources at present to provide an independent person. However, cases were reviewed by project team on a weekly basis.
9	There are clear discharge plans in place for all children placed in special care.	All but two young people have discharge plans. Two outstanding letters going to Local Health Office Manager requesting same	Director BSCU	October 2010	Recommendation met in part. There were discharge plans for the majority of children. Onward plans (despite having these identified on admission) were an issue in three cases due to changing needs of the children during placement and consideration as to what is in the best interests of the child.

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
10.	There is a nationally directed requirement issued to all social work departments for referring social workers to read SCU inspection reports and monitoring reports prior to making referrals and to visit SCUs at the point of referral to satisfy themselves that the intended placement is suitable and safe. Social work managers to be held accountable if they have not.	Memo to be issued	National Manager	October 2010	<p>Recommendation met.</p> <p>Inspectors were given a copy of the memo issued.</p>
11	Children's access to information is reviewed with staff to ensure that staff understand and actively promote and facilitate this child's right.	Children's access to information will be reviewed with staff at the Staff Meeting on 10 September 2010 and on an ongoing basis thereafter.	Director BSCU	Completed	<p>Recommendation met.</p> <p>Minutes of this meeting were reviewed by inspectors and children interviewed were informed of their right.</p>

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
12	Staff encourage and enable the children to meet as a group on a regular basis to discuss issues as required by the standards.	Young People's Meetings are occurring weekly in both centres and minutes taken.	Director BSCU	Completed	Recommendation met. Inspectors reviewed minutes of these meetings and children interviewed confirmed that they occurred.
13	Nationally, there are clear lines of accountability of all special care units to a person with national authority.	Implementation plan drafted for this.	National Director	End September 2010	Recommendation not met. The transfer of operational responsibility of the National Special Care and High Support Service from the Office of the Assistant National Director of Children and Family Social Services to the Regional Director of Operations for Dublin North East planned to take place on 13 November 2010 did not occur.
14	There is clarity of governance and reporting relationships.	Implementation plan drafted as above	National Director		Recommendation met. (See No. 13 above)
15	Forums, such as staff meetings and handover meetings	Team meetings and handover meetings take place regularly	Director BSCU	Completed	Recommendation met. Inspectors reviewed minutes of these meetings.

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
	are maintained to ensure for clear communication between staff and continuity of care of children.				
16	The standard on recording, maintaining files, security and archiving files is fully compliant with legislation, regulation and standards.	The Head of Care has been assigned responsibility to ensure that the standards on recording, maintaining files, security and archiving files is fully compliant with legislation, regulation and standards. All files referred to in the inspection will be archived.	Director BSCU	September 2010	Recommendation met. Inspectors reviewed files on the Unit and noted an improvement in the standard of recording. Files that had previously been stored in an insecure manner were now archived offsite.
17	The SCU notifies all significant events to relevant parties without delay and promptly provides detailed written reports as required by the relevant social work departments and other professionals who have a right to the information.	National Policy on Notification of Significant Events has been issued.	National Manager SC and HS	Completed	Recommendation met. As per National Policy dated 25 May 2010 all significant events were reported to relevant parties without delay. Detailed written reports were made available to social workers on request.

No.	Recommendation	Action to be taken	Person responsible	Implementation date	Follow-up inspection SSI response (Inspection ID No. 591)
18	A HSE national policy is developed on the use of computer for information purposes in all care settings, and clear guidance should be issued to staff about the maintenance of records generated on computers.	HSE training department will draft a policy in conjunction with IT. Once signed off staff training will commence	National Manager Training Department.	November 2010	<p>Recommendation met in part. A policy was being re-drafted.</p> <p>A copy of the agreed policy should be provided to HIQA SSI on completion.</p>
19	A full risk assessment of the current facilities is carried out by a competent person independent of the line management structure without delay, including in the assessment, the potential for self-harm.	The HSE Health and Safety Department have already commenced a full risk assessment and a plan will be developed in conjunction with BSCU to address all health and safety issues	HSE Health and Safety Department and Director BSCU	End of Sept 2010	<p>Recommendation met in part. Risk assessments were being carried out on all aspects of the special care campus and were due to be completed by November 2010.</p> <p>A copy of the completed risk assessment should be provided to HIQA SSI on completion.</p>

3. Conclusions

The follow-up inspection concentrated on the progress made by the HSE to address the recommendations of the July 2010 inspection. While there was evidence of some improvements in the décor of the building, notification of significant events and other care practices in the Unit, there were concerns about the increased demands for special care placements and the inability of the HSE to meet these needs. There remained a lack of clarity on the new national model of special care and high support services.

The planned transfer of the management and operational responsibility of Ballydowd SCU has not happened. The management of the Unit had been due to move from the National Special Care and High Support Management Team to centralised HSE management under the umbrella of the Regional Director of Operations (RDO) for Dublin North East in November 2010. This has now been extended to January 2011. Inspectors are concerned that this proposal is a key element to the HSE strategic and operational development of the service. However, ongoing delays with the handover of the service to the RDO national structure threaten the ability of the Unit to carry out its functions. It is therefore critically important that this management structure be put in place as a matter of urgency.

4. 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: Coovagh House Special Care Unit (Report ID No. 590) and Gleann Alainn Special Care Unit (Report ID No. 589) and the Overview Report. These reports are on the Authority's website, www.hiqa.ie.

This follow-up inspection of Ballydowd 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 that 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.