



**SOCIAL SERVICES  
INSPECTORATE**

**A CHILDREN'S RESIDENTIAL CENTRE IN  
THE NORTHERN AREA HEALTH BOARD  
COMMUNITY CARE AREA 6**

**INSPECTION REPORT**

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## **1. Executive summary**

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre from 30<sup>th</sup> September to 2<sup>nd</sup> October 2003. The centre was located in Community Care Area 6 (CCA6) of the Northern Area Health Board (NAHB). The centre offered a regional short to medium service for family groups of children up to 17 years. It also offered direct support to their parents.

At the time of inspection a sibling group of five children lived at the centre and their parent had been living there intermittently. Inspectors found that the centre offered a good quality of care and emotional support to both the children and their parent. The centre manager and staff team were enthusiastic and committed to direct work with the parent and children with the aim of trying to re-establish them in their home.

The children were well cared for and were involved in many activities locally and had maintained links with their own community. The parent was involved in some of the parenting tasks within the centre and was also provided support from the staff in relation to personal issues.

Inspectors were impressed with the centre's commitment to assisting the family. The emotional support given to the children enabled them to develop trusting relationships with the staff, and over time it was evident that the children were forming significant attachments. The parent, who resided in the centre intermittently, said she felt supported by staff. The role of the parent in the centre when the children were admitted helped them to settle, however, inspectors found there was some confusion between the role of the parent and the staff in the centre.

The children had access to their files and useful information around health and safe care was promoted the children's educational potential was well supported and the staff involved the parent in sustaining links with the schools.

The centre was located in an established estate, was decorated to a good standard, and was homely, warm and inviting. There was enough space for the children to do their homework quietly, or have a chance to talk directly with staff about issues concerning them. The neighbours were supportive of the centre, and the children played in the close with their neighbours' children. The provision of food was excellent, and the children could prepare snacks for themselves if they wished. The children enjoyed good health and had access to health services as needed.

The standard of management at the centre was good and staff said they felt supported in their work. Inspectors noted that all staff had Garda clearances and three references before commencing employment as required by the Department of Health and Children's guidelines. The board was supporting unqualified staff in the centre attain qualifications. Inspectors found the management structure and team had enthusiasm and commitment to making the centre a positive experience for both the children and the parent.

Inspectors had concerns that there was not a formal agreement within the board on the purpose and function of the centre. There was confusion about some aspects of the service, such as the parent living there and having unrestricted access to her children.

From spring to summer 2003, there were major shifts and absences in key management and strategic posts within the NAHB. The most significant of these was that there was no social worker for four months (during the extended leave of the social worker allocated to the family). This had an impact on maintaining clear lines of communication between the centre and board professionals. The standard on notification of significant events and visits by the supervising social workers were not met. This was of particular concern as some of these events warranted a children protection assessment. The board is advised to review its training and practice for staff in relation to Children First: The National Guidelines for the Protection and Welfare of Children.

Care planning did not meet the standard. The care plan for the eldest child, intended as a template for the plans of the other children, had been mislaid. Plans for three of the children were prepared in September 2003, well outside the statutory timescales. Since the plans were drawn up only shortly before the inspection there had been no reviews. As the placement was time-limited this meant that the children had already been in the centre for half of the intended term with no plan.

Inspectors found that the centre had not been monitored in accordance with the regulations and that for some months the children did not have a visitor from outside the centre to check upon their happiness and well being. Since the field work was undertaken, the board has appointed a full time monitor.

Amongst other issues, inspectors made recommendations about an agreed statement of purpose and function, staff training, permanency for qualified staff, notification of significant events, systems of communication, revision of the complaints procedures, monitoring, risk assessment and risk management, multidisciplinary assessments and psychological consultancy to staff, introduction of a keyworker system, review of methods of recording, and procedures and training in Children First.

Overall, inspectors commend the board for its commitment in developing this residential service to work with parents on issues that brought the children into care. This centre provides parents with an opportunity to be reunited with their children.

Between the fieldwork and publication of this report, inspectors were pleased to learn that the board had implemented a number of the recommendations of the report.

## **2. Introduction**

The social services inspectorate (SSI) carried out an announced Inspection of a Children's Residential Centre in Community Care Area 6, (CCA6) of the Northern Area Health Board (NAHB) on the 30<sup>th</sup> September to 2<sup>nd</sup> October 2003. A pre-inspection visit took place on the 22<sup>nd</sup> September 2003 and inspectors met the manager and various staff to discuss the process of the inspection. Lorraine Edwards was lead inspector, and Michael McNamara acted as support inspector.

### **2.1 Methodology**

The inspectors had access to the following documents during the inspection:

- A statement on the purpose and function of the centre,
- The centre's statements of policies and procedures,
- The young people's case files,
- The young people's daily log books,
- All administrative and recording systems,
- Questionnaires completed by teachers,
- Census forms on staff members,
- Census forms on young people,
- Correspondence to the inspectors from GPs,
- Staff rotas,
- The centre's health and safety statement.

During the inspection three children and a parent met with inspectors They also interviewed the acting centre manager, five care staff, the general manager of CCA6, the acting child care manager, the outgoing and incoming principal social workers, a social worker team leader, two social workers, the alternative care manager for CCA6, and the board's monitor.

### **2.2 Acknowledgements**

Inspectors acknowledge the assistance and co-operation of the young people, parent, centre staff, social workers and health board managers.

## **3. Setting the scene: background, the unit and its population**

### **3.1 Background**

The centre had previously operated as two separate centres adjacent houses. One of the properties was smaller than the other. The board decided that, in order to cater for larger groups of siblings the two houses should be combined. A number of families were identified by the alternative care manager and principal social worker as potential service users.

A review of the purpose of the centre took place in 2002, and early in 2003 an acting centre manager and staff were recruited. The combining of the two houses was not completed until May 2003. The family seen during the inspection had been in the centre since it opened in its re-organised form on 13<sup>th</sup> May 2003.

### 3.2 *Data on Young People*

There were five children from one family in the centre. From time to time since their admission their mother had also lived in the centre, but she was not resident at the time of the inspection. The ages, care status, previous placements, and length of stay of the young people are shown in the table below.

<i>Young person</i>	<i>Age</i>	<i>Length of time in the centre</i>	<i>Legal Status</i>	<i>Previous placements</i>
Female	14 years	4.5 months	Voluntary care	Foster Care
Female	12 years	4.5 months	Voluntary Care	None
Male	10 years	4.5 months	Voluntary care	Foster Care
Male	9 years	4.5 months	Voluntary Care	None
Female	7 years	4.5 months	Voluntary Care	None

## 4. **Standards: the findings**

### 4.1 *Statement of purpose and function*

**The unit has a clear written statement of purpose and function which accurately describes what the unit sets out to do with children and the manner in which that is provided. The statement is available, accessible and understood.**

There was a clear statement of purpose and function contained in a policies and procedures document. It had been drafted after the opening of the centre by the manager and another member of staff. They received support in preparing the document from the board's training unit. It had been approved by the alternative care manager for CCA6, but at the time of the inspection it was awaiting feedback and endorsement from others including the general manager, the newly appointed principal social worker, and the acting child care manager.

In the view of the inspectors, it would have been useful if the statement of purpose and function and the policies and procedures had been prepared prior to the reopening of the centre. This would have allowed all those involved reach consensus on the purpose of the centre. As it was, inspectors found that there were widely varying views about what the centre was set up to do, particularly about the extent of the inclusion of parents as residents in the centre alongside their children.

The statement of purpose and function said that the centre was to provide short to medium term residential care, that is up to between six and nine months, for children up to 17 years. It was managed by CCA6, but took referrals from the three NAHB community care areas. Its primary focus was on sibling groups, and the centre's function was to carry out work with families, both children and their parents, with a view to rehabilitation back to their own homes.

Inspectors are in support of the overall aim of the centre to work with parents and children so they can live together in the future. However, there was a lack of clarity and agreement amongst board personnel regarding how this was to be achieved, balancing parental and children's needs.

In relation to the family in residence at the time of the inspection, inspectors were told by the alternative care manager and the acting centre manager that the inclusion of the parent as a full time resident was integral to the newly defined function of the centre. However, managers of the social work team said that they were unaware of this, and one of the social workers assigned to the case, said that it had been assumed that the parent was in the centre simply to assist the children in their transition into care.

While all parties saw the centre as providing a service that would undertake some assessment work through observations of the parent's interactions with their children, staff did not have access to suitable training or consultancy to enable them to undertake a full assessment. Considering the complexities of the problems faced by the families that are referred to residential care, inspectors were of the view that the board should use multi-disciplinary assessments in order to match the service provided by the centre to the needs of the family, particularly the children. This would provide the centre with some guidance on whether the referrals were suitable and provide a foundation for the work of the centre. As the placement is so short term early assessment of the needs of the children is essential. Where there are child protection concerns, risk assessments and risk management action plans would also provide an agreed framework for some of the day-to-day decisions staff have to make.

The principle of 'unrestricted access' by parents, as enshrined in the statement of purpose and function, had a significant impact on the day-to-day running of the centre. The boundaries between the authority of the parent and the staff in terms of the care of the children while they were in the centre had not been defined. Concerns were expressed by members of the social work team as to how the responsibility for decision making could, in all instances, be effectively shared by the staff and parent. Although the centre's aspiration was to work in partnership with the parent, inspectors found evidence that this had not worked in some situations, and staff found themselves having to make judgements between parental decisions and the best interests of the children.

Inspectors are of the view that the board should review the statement of purpose and function, taking into account the principle of unrestricted access, and define the boundaries of responsibility and authority for staff and parents.

### **Recommendations**

- 1. The board should review the purpose and function of the centre paying particular attention to the role of parents and staff.**
- 2. The board should introduce multidisciplinary assessments and risk assessments at the time of referrals of families to the service in order to ensure that the centre can meet the needs of the children placed there.**

## 4.2 *Management and care staffing*

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

### 4.2.1 *Management*

The centre was run by a suitably qualified and experienced person. He held a full time temporary post as acting centre manager. He reported to the alternative care manager, who in turn reported to the general manager of CCA6. The alternative care manager had responsibility for all the residential centres and some aspects of fostering in CCA6.

The manager worked between nine and five each day up to thirty-nine hours a week, and provided on-call cover to staff outside his shift hours. He received regular supervision from his line manager. Inspectors were told that if differences arose between himself and his line manager the acting centre manager could make a direct approach the general manager.

There was no deputy manager at the centre. At times this resulted in inconsistency in the centre. For example when the acting centre manager took a three week period of leave his post was covered by a different person each week. Staff told inspectors that this had caused problems in directing their work with the family. Inspectors urge the board's managers to consider a consistent option for on-call cover.

The centre staff was positive about the leadership and support offered by the manager. Inspectors found that there was an ethos of working together as a team, and recognition by individual staff of the manager's role in accessing training opportunities and promoting staff development.

The manager's style was described as inclusive, involving the team in discussions in planning for the family and facilitated the use of individual skills of the members of the team. Team meetings were described as occasions when staff could share experience and knowledge in a professional and open manner.

Inspectors praise the commitment of the manager and staff team to their work in the centre. Staff interviewed by inspectors was enthusiastic about the centre's involvement with the parent of the children. Staff also told inspectors that they felt supported by the alternative care manager during the developmental stages of the service.

### **Recommendation**

#### **3. The board should introduce a consistent system of on-call cover for the acting centre manager**

#### **2. *Care staffing***

The centre had 12 staff including the full time temporary acting centre manager. There were six full time permanent and one full time temporary staff in child care worker posts working 39 hours a week. One of the full time permanent staff was a trainee child care worker. There were also one part time permanent and three relief staff. The relief staff were employed to relieve staff to attend training courses. The majority of the staff came

from the original two houses at the site. All staff commenced employment in the centre on 13<sup>th</sup> May 2003.

The staff group represented a wide range of life and care experience. The average age was 34, and the average length of service in residential settings was nearly four years. A third of the staff group were male. Details of qualifications and length of service are given in the table below.

**CRC Staff – September 2003**

<i>Care Staff</i>		<i>Length of Service</i>		<i>Employment Status</i>	<i>Qualifications</i>
		<i>In Child Care</i>	<i>In Centre</i>		
#1	Acting Centre Manager	8 years	3 months	Full Time Temporary	National Diploma in Applied Social Studies in Social Care BA Psychology Diploma in Counselling
#2	Child Care Worker	4 years	3 months	Full Time Permanent	No qualification
#3	Child Care Worker	3 years	3 months	Full Time Permanent	BA Theology
#4	Child Care Worker	3 years	3 months	Full Time Permanent	No qualification
#5	Child Care Worker	4 years 7 months	3 months	Full Time Permanent	No qualification
#6	Child Care Worker	4 years 9 months	3 months	Part Time Permanent	No qualification
#7	Child Care Worker	7 years 3 months	3 months	Full Time Permanent	Diploma in Nursery Nursing
#8	Trainee Ch C Worker	4 months	3 months	Full Time Permanent	No qualification
#9	Child Care Worker	7 years	3 months	Full Time Permanent	National Diploma in Applied Social Studies in Social Care
#10	Child Care Worker	1 year 7 months	3 months	Relief	No qualification
#11	Child Care Worker	10 months	3 months	Relief	No qualification
#12	Child Care Worker	3 years	3 months	Relief	No qualification

Inspectors found that three staff was assisted by the board in attending qualification training courses. The manager expressed some concerns about feedback from training institutes in relation to staff advancement on courses, in particular attendance and overall progress. This could be an area for development by the alternative care manager and the board's own training centre.

The board is commended for the fact that all staff, including relief staff, had Gardai clearances and three references prior to the opening of the centre in May 2003.

Inspectors were shown a copy of the NAHB's draft action plan for residential care. One of its objectives was to ensure that all relevant posts in the residential services were made permanent in order to provide consistency and quality through staff with appropriate knowledge and skills.

In the staff team seven out of ten unqualified staff was permanent, while the only two staff that was qualified in child care were temporary. The centre manager, who was

qualified, was in an acting post. Inspectors were informed of anomalies in the pay between temporary and permanent posts and urge the board to resolve these matters.

## **Recommendation**

### **4. The board should endeavour to secure qualified staff in permanent positions.**

#### **4.2.2 *Supervision and support***

Inspectors found that there was a good system of supervision and support within the centre. The centre's procedures for supervision were in draft at the time of the inspection. Inspectors advise that they are reviewed by managers of the board to ensure that they are consistent with board-wide policies on supervision.

At the time of the inspection the frequency of supervision was every eight weeks. New staff had supervision every four weeks. A supervision record was held on each staff member at the centre and was signed by the parties involved. Staff interviewed by inspectors valued the sessions they had with the acting centre manager, and saw them as good opportunities to evaluate their work and professional development. However, even though they understood the pressures of the manager's post they felt that sessions should be more frequent than two monthly. The board told inspectors that arrangements for supervision training for managers had been made.

The team meetings also formed a basis for support and supervision. They were held weekly. Staff and the managers said they saw them as vital for team development. Staff were encouraged to bring practice issues to the meetings and to share concerns. Some of the meetings had a different focus because the parent of the children attended them when she was resident in the centre. The staff team endeavoured to include her as a partner in their team approach to the care of the children.

Inspectors shared the concern expressed by some of the staff that they did not have access to expert consultation to assist them in the care of children with complex needs. The manager told inspectors that he is hoping to have access to a psychologist shortly to advise on the teams' work with the family. Inspectors support the initiative for regular consultancy, particularly in relation to issues relating to child development, attachment, separation and loss. This is of particular significance to the team given their overall level of experience and qualification and the range of children's needs they are trying to meet.

### 4.2.3 Training and development

Details of the training received by staff are shown in the table below.

**Children's Centre – Staff Training – September 2003**

	1	2	3	4	5	6	7	8	9	10	11	12
	Acting Centre Manager	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Trainee Ch C Worker	Child Care Worker	Child Care Worker	Child Care Worker
<i>Children First (Briefing)</i>		✓	✓	✓	✓	✓	✓		✓	✓		
<i>TCI (5 days)</i>		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
<i>First Aid</i>		✓	✓	✓	✓	✓	✓			✓		
<i>Drugs Awareness</i>	✓											
<i>Report Writing</i>	✓											
<i>Bereavement</i>									✓			

The board's training centre offered useful assistance to the manager in developing policy and procedures. Ten staff had received therapeutic crisis intervention (TCI) training; however two team members are awaiting training. The board's policy is that all staff should be trained in this method. Eight staff received briefing training in Children First: the National Guidelines for the Protection and Welfare of Children.

Inspectors recommend that the alternative care manager and the acting centre manager carry out an audit of training needs, and, on this basis draw up an action plan for staff. Informal induction for staff was completed in the period between the closure of the old unit and the opening of this centre. At the time of the inspection, one new member of staff had received formal induction training.

Inspectors suggest the following as areas where training is needed: Children First, risk assessment and risk management, child development, managing challenging behaviour, assessing and promoting parental skills, health and safety, and fire safety.

### **Recommendations**

- 5. The board should carry out a training audit and develop a plan for the staff team.**

### 4.2.5 Administrative files

The recording systems were well organised and maintained. They were clear, accessible, and up-to-date. Children's records were of a high standard. They are referred to in detail in 4.5.8 below.

#### **4.2.6 Notification of significant events**

The standard for notification of significant events requires that a health board is satisfied that the centre has prompt notification procedures.

Inspectors found several significant events and serious incidents that were not brought to the attention of the social worker. On examination of the records inspectors found that staff were unclear about what constituted a significant event, and about what information should be passed on to social workers.

For example, an incident sheet record on one file outlined that staff had made a restraint, and the child had made a complaint alleging assault by a member of staff. The child later withdrew the complaint. However, neither the precipitating incident leading to the complaint or its withdrawal was made known to the child's social worker. Inspectors found evidence of other events that warranted notification to the social worker which had not occurred. Where notifications were made about some incidents there were delays, sometimes of several days, before the information reached the social worker.

Overall, the standard for notification of significant events was not met. Inspectors recommend that the acting centre manager, the principal social worker and the monitor agree what constitutes a significant event and the notification procedure. The acting centre manager should develop procedures and practice guidance and provide training for staff to enable them to identify significant events and report them promptly to the social worker and the monitor. The monitor for the centre should carry out regular checks on the centre's system of notification.

#### **Recommendations**

- 6. The acting centre manager should ensure that significant notification of events is carried out in accordance with National Standards and board policy.**
- 7. The monitor should carry out regular checks to ensure that the notification of significant events in the centre is in accordance with the standard.**

#### **4.2.7 Register**

The centre had a register. However, it did not record all the details required by the regulations. Inspectors were told by the acting centre manager that the board did not have a duplicate of the register as required by the standard. Instead, weekly 'activity data sheets' were sent to a central office of the board. These formed a record of what children were in residence in the centre during the preceding week. In order to meet the standard the duplicate should be a replica of the register kept in the centre.

#### **Recommendation**

- 8. Managers should ensure that the standard on keeping the register is met.**

### 4.3 *Monitoring*

**The Health Board, for the purpose 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.**

The NAHB had assigned the role of monitor to three alternative care managers, each of whom managed alternative care in one of the board’s three community care areas. The managers had responsibility to monitor the children’s residential services in one of their colleague’s areas.

At the time of the inspection the centre had recently been allocated to the monitor who was the alternative care manager for CCA8. Apart from her responsibilities for alternative care she also had a special arrangement with a group of twelve staff to manage.

Whilst the monitor was not part of the line management of the centre, inspectors are of the view that the role of alternative care manager and monitor, albeit for different areas, had the potential for a conflict of interest. Inspectors urge the board to appoint a dedicated monitor who can give full attention to the monitoring role.

Since the field work inspectors learned that the NAHB has appointed a full time monitor.

### 4.4 *Children’s rights*

**The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.**

#### 4.4.1 *Access to information*

Inspectors found that the children in the centre were encouraged to seek information on themselves in their files and daily logs and this had occurred. The daily log book was of a high standard. It was clear and accessible to children. Inspectors were given a draft information booklet for children entitled “All about Living Here”. This gave details on how to make complaints, names of social workers, staff and significant professionals, acceptable behaviour, care plans, and education. The standard for access to information was well met.

#### 4.4.2 *Consultation*

There was a high standard on consultation with children in the centre. Efforts were made to include the children in the weekly team meetings. Their views were sought on daily routines like meals and outings. They had not been consulted in relation to the review of their care plans as this standard was not met.

#### 4.4.3 *Complaints*

The centre had a written policy for complaints consistent with that of the NAHB. There were clear procedures within the centre, and the children interviewed by inspectors were able to talk about the forms that could be filled in by them if they had any complaints.

They had confidence that these would always be addressed by the manager. They said that if they had any worries they would tell him.

On examining records in the centre and interviewing staff however, inspectors found that there was confusion amongst staff about what constituted a complaint. There was a significant confusion between complaints about everyday aspects of daily life in the centre and more serious matters such as allegations of abuse. In interviews with the social work team inspectors were told that there had been no formal complaints since the children had been admitted to the centre in May 2003. While this was the case, the records indicated that there were situations in which children expressed unhappiness about an aspect of life in the centre, and in one instance an allegation of assault by a member of staff referred to in 4.2.5 above, but these were only recorded in the general records.

The system for dealing with complaints needs review. In particular, it should be clear to staff exactly what constitutes a complaint, and the procedure for recording it should be separate from the general records. The centre's procedures should be known to the social workers, child care managers and the monitor. The system should be regularly checked by the alternative care manager and the monitor. Parents should be informed about the complaints procedure. Allegations of abuse should immediately be referred in accordance with the board's implementation of Children First, and withdrawal of an allegation should always be accepted only after it has been confirmed by the child's social worker. It is not best practice for withdrawals of allegations about staff to be accepted by centre's staff without consultation with the social worker.

## **Recommendation**

### **9. The ACEO should review the centre's system for dealing with complaints**

#### ***4.5 Planning for children and young people***

**There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.**

##### ***4.5.1 Suitable placement and admissions***

The centre's referral process was outlined in the policy and procedures. Referrals were taken from the three CCAs in the NAHB, and parents had to be in agreement with the placement.

Referrals were processed through a written request to the alternative care manager. These were discussed at a referrals committee which consisted of the acting centre manager and two members of staff. Inspectors were concerned about the balance of this committee, and suggest that the board consider including someone outside the immediate line management of the centre. The referral procedures did not make clear to social workers what information was required of them. The acting centre manager told inspectors that he was revising the procedure to address this problem.

The placement of the family residing in the centre at the time of the inspection was deemed suitable by the supervising social worker and acting centre manager because it allowed the children remain together, it removed them from circumstances of risk, and it offered an opportunity for the parent to address issues that led the children coming into care.

Inspectors were told by the social worker that other options such as fostering might have been considered had they been available. The principal social worker said that the centre was specifically set up so that larger sibling groups could be received into care and kept together. Many interviewed agreed that keeping the children together was a major advantage for placement at the centre.

After the family were referred to the service in October 2002 there was a seven month delay before the admission took place. Inspectors were told that the delay was attributable to several factors including waiting for building work to be completed. The delay was of particular concern because social workers and centre staff said that the children were being received into care primarily on the basis of their being at risk.

On interview the parent said that the delay had an impact on the children. For example they asked weekly when they would be admitted to the centre. However, she also said that the support given to the children during the transition from home to the centre was good. The uncertainty and delays in admission to the unit did impact on the children and the board should consider arrangements to ensure that this does not happen.

## **Recommendations**

- 10. The board should appoint a person from outside the immediate line management of the centre to the referrals and admissions committee.**

### **4.5.2 Statutory care plans and care plan reviews**

Under the regulations statutory care plans should be in place before or as soon as practically possible after the young person comes to live at a centre. As the decision for the children to come into care was made in October 2002, the Inspectors expected to see care plans prepared in advance of admission. Inspectors were told that care plans were prepared for the two eldest children within two weeks of admission, and that the written care plan for the oldest child was the most complete, and outlined the common elements of the main care plan for the other children.

Records in the centre and the accounts of the social worker and the acting centre manager confirmed that the planning meeting took place and that the children took part in the process. However, the statutory care plan for the eldest child on which the others were to be based had been mislaid and was not available. The centre staff had highlighted their concerns to the social worker verbally and in writing about not having this care plan or a duplicate on the child's file. The centre staff also highlighted this as a problem to inspectors as the other care plans were sketchy. There was a considerable delay in completing the care plans for the other children and they were outside the statutory timescale.

The consequence of the missing care plan for the oldest child was that the remaining care plans on four of the children were incomplete. It was intended that these would be read in conjunction with the plan for the oldest child. The care plans for the three younger

children drawn up September 2003, four months after admission, showed evidence of consultation with the children, parent and centre staff. However, inspectors could not find written evidence of any agreement about the role of the parent even though it was described in interviews with centre staff as a central plank of the plan. Since the 'template' plan was missing and the others had been prepared only weeks before the inspection there had been no care plan reviews. The regulations require that these should take place within the first two months of the placement. In this instance that would have been in mid-July 2003.

The NAHB care plan format was detailed and extended to over 30 pages. Inspectors noted that some sections of the format were not completed, and that signatures and dates were missing. In some plans there were anomalies in the order of priority given to needs, such as giving a recreational need for a child with learning difficulties precedence over educational plans.

The standard for care planning and care plan reviews was not met. The board should introduce strict monitoring of care plans by the monitors to ensure that they are in place when children are received into care, and reviewed within the timescales of the regulations. Inspectors advise a review of the care plan format to establish whether it is as effective an instrument in the planning process as was intended. There should be a requirement that the form is completed for each individual child that the plan is dated and signed by all the relevant signatories, that the centre and all others who have a right to have a copy receive it without delay, and that copies are put immediately into a secure recording system.

## **Recommendation**

**11. The board should arrange for the immediate development of full care plans for all the children and reviews of care planning should be held in compliance with regulation.**

### ***4.5.3 Contact with families***

Inspectors were pleased to see that where possible the centre had striven to assist the children in maintaining their local network of contacts with extended family and friends. The ethos of the centre was to encourage family contact as much as possible. This was evident during the inspection. Both the parental and extended family contact with the children helped in facilitating the children's adjustment to their new circumstances.

#### 4.5.4 *Social work role*

**Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to any aspect of their care.**

The social work team had been working with the family since August 2002. The focus of the team was to support parents to change their lives and circumstances so that their children could live safely with them in the community. A foster care option was used for a brief period with two of the children. The teams' concern was for all the siblings and the benefits of keeping them together, and so they were admitted to the centre with their mother.

Inspectors were told that the actual admission process for the family was positive. The social worker is commended for her work in this regard. There were overnight stays for the family before full admission. However, problems arose following the social worker's going on extended leave a few weeks after the family's admission. She was not replaced and this left a period just short of four months when no one was driving the care planning process, monitoring and acting on significant events, or carrying out supervisory visits to the children.

Inspectors had concerns about the lack of understanding between the social work team and the centre team about the role the parent was to play in the centre. Inspectors were told the former understood the parent was to stay in the unit only until the children were settled, while the centre understood that the parent would stay on an ongoing basis. This breakdown in understanding about the work of the centre was caused in part by the absence of a social work input at a crucial stage in the development of the centre.

Inspectors found that the children were confused about their future plans. Inspectors interviewed the new social worker and team leader and they acknowledged that problems arose during the absence of a social worker, and outlined plans for greater proactive involvement with the family and the centre.

There were differences in the work of the previous and the current social worker. The previous social worker worked with the parent on her own problems, as well as issues concerning the children. The current social worker only worked with issues directly concerning the children. This conflicted with the centre's aim to work with the parent on all pertinent issues. Inspectors advise the centre and social worker negotiate a coherent working strategy.

On examination of the centre's records inspectors found that the acting centre manager in the absence of the social worker carried out a number of the tasks which properly belonged to the social work team. While this enabled the plans within the centre to progress, the standard for the supervising social worker's involvement in the centre was not met. Inspectors recommend that the board ensure that children in residential care have allocated social workers and that there are contingency plans to cover their duties in the event of extended leave.

## **Recommendation**

**12. The alternative care manager and principal social worker should ensure there is effective communication between them on issues of mutual responsibility.**

**13. The board should ensure that children in residential care have an allocated social worker, and that there are contingency plans to cover the social worker's duties in the event of extended leave.**

### ***4.5.5 Emotional and specialist support***

Inspectors were impressed with the level of emotional support and care offered by the team to the children. The children were beginning to form attachments to staff. Inspectors noted that there was no keyworker system in the centre. This was explained that the staff wanted the children's parent to remain at the centre of their focus. The family was seen as a group with the parent as the main emotional support. The wish to sustain the children's attachments to parent meant that their attachments to staff were not promoted to the same extent as they might be if they had less contact with their parent.

Inspectors understood the staff team's efforts to support relationships within the family but caution that as the period in the centre is to assess if the children can remain with their parent there is a possibility that the children, or individual children, will remain in care. In order to more fully undertake an assessment of these issues, and to attend to the different needs of the children, the centre manager should consider the appointment of key workers for the children. The extent of the intervention of the key worker can be determined as the placement progresses and the manager would have to work closely with the key workers to ensure the parent was not being overwhelmed with key workers or given contradictory advice.

There were periods during the children's placement where their anxieties grew. They were unsure of their future and their parent's capacity to meet their needs. At times such as these, the children's need for help and reassurance with their feelings of loss and anxiety should take priority over the overall aim of the centre.

With regard to specialist support outside the centre, inspectors were impressed to hear about provision of services at a school that one of the children attended.

The centre was supported by specialist support from the school of one of the children. The centre had been proactive in accessing play therapy for two of the children and had referred another for bereavement counselling.

Inspectors were told by the manager that he hoped to access support from a consultant to advise the staff team in relation to the work with families. Specialist support would be required in order to progress work with parents as well as the children. This is referred to and the subject of a recommendation in 4.2.3 above.

## **Recommendation**

**14. The acting centre manager should introduce a key worker system appropriate to the service provided by the centre.**

#### ***4.5.6 Preparation for leaving care and aftercare support***

The centre's policies and procedures document outlined the aftercare work to be provided when a child returns home. At the time of the inspection there had been no discharges from the centre, and therefore, no after-care programme had taken place.

#### ***4.5.7 Discharges***

Where possible the centre was committed to planned discharges. The plan was that the family should be discharge to an environment that is deemed suitable for their emotional and physical needs. If an emergency discharge were necessary or a family requested to leave then a meeting with all relevant parties would be called before a formal decision were made.

#### ***4.5.8 Children's care records***

The children's care records were well maintained. Inspectors were of the opinion that there was scope to improve the security of the system so that sections of file did not have the potential to go missing or be altered. The current system was that they were kept in a filing drawer in a cabinet and divided in to fifteen loose files. They also suggest the introduction of an index so that it is clear what should be in a file and access is facilitated. Inspectors found that the children's birth certificates or a copy were not on the children's files.

Inspectors examined samples of all the administrative records and found that they were consistently maintained. The daily log book on each child was very impressive and was kept in a customised hard back book. The information in these logs was signed off by the staff, countersigned by the manager, alternative care manager, and on occasion by the social worker. Inspectors were impressed with the aspect of the children's care records. There was evidence of placement plans, produced by the centre staff, which identified staff to carry out various tasks in order to implement the plan.

There was a court report prepared by a social worker which gave a synopsis of the involvement of the board with the family, but it was not dated or signed. Inspectors were concerned that there were no social histories on the files as required by the regulations. They concur with the centre manager and staff in their wish for more written information for their care files.

On inspecting the files there were some records that were poorly written or did not make sense. However, there was evidence that this was picked up by the acting centre manager and his comments and advice were noted on file. This was evidence of good practice by the acting centre manager, and inspectors urge him to continue it.

## **4.6 Care of young people**

**Care staff relate to young people in an open, positive and respectful manner. Care practices take account of young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities and leisure experiences to their peers and have opportunities to develop talents and pursue interests. Care staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.**

### **4.6.1 Individual care in group living**

Staff are commended for the quality of daily care provided to the children in the centre. The children seemed happy and secure and there was a sense of warmth and homeliness within the centre. Staff said that the children found the transition into care difficult and the staff team worked hard to build up their confidence and trust. There was some disruptive behaviour, but staff were able to work with the children on issues such as self control, bullying and loss.

The role of the parent was significant in the early stages of the placement in the care of the children. The parent was able to assist staff in quickly gaining an understanding of the children, particularly in terms of their daily routines and likes and dislikes. At times, they were totally engaged with working with the children. This could range from cooking supper, helping them with their homework, or spending time with staff in looking at day-to-day plans for the children.

Children were included in the day to day running and planning of the centre. For example, suggestions made for social/sporting activities by the children were acted on where possible. The children and the parent were invited to the weekly team meeting. However, the parent's perception was that the children thought the meeting occurred if they did something wrong and so they rarely attended. As indicated in 4.5.5 above, inspectors thought that a key worker system for the children would enhance the care overall.

The parent and the girls each had their own room. The two boys shared a room and they told inspectors this caused some difficulties as they said they sometimes fell out with each other, the sleeping pattern of one disturbed that of the other, and there were some worries about keeping their things private and safe. They were also concerned that as a result of them sharing a room they were not able to have their friends to stay overnight. The issues they brought up were not unlike those of siblings in any family. Where possible, the standards state that children in care should have their own bedrooms, however, this is of particular note where the children are not related or do not have a particular friendship with any of the others. Staff have to be attentive to safety issues, especially where there are significant age differences between children. Inspectors advise that in this instance, staff should work with the boys to help resolve the problems they described, especially if there is a possibility of their continuing to share should they leave the centre to live at home again.

### **4.6.2 Provision of food and cooking facilities**

The standard of food provision within the centre was excellent. The children themselves take it in turns to go food shopping. There was evidence of the children regularly cooking with the staff.

The children's eating patterns were recorded on their files. If there were any issues in relation to diet then this would be addressed in the placement plan. The parent was especially happy with the provision of food for the children. The staff used "food charts" with the children to get them interested in healthy eating habits.

There was evidence that meals were well planned and varied. The children were encouraged to sit down together with their parent and staff for meals. On occasions they would have take-outs. The children could also help themselves to snacks if they so wished.

#### **4.6.3 Race, culture, religion, gender and disability**

The children did not attend Mass on a regular basis as they choose not to. However, the parent felt that the children should not have a choice about attendance and she wished staff would enforce her views with the children. Inspectors are of the view that there should be further discussion between the staff and the parent on this issue. It is important that the parent's views are seriously considered, and staff should try to create an atmosphere where attendance at Mass was a regular occurrence, especially with the younger children.

An area that the staff team worked with well was learning disability as one child had special needs.

#### **4.6.4 Managing behaviour**

The centre staff demonstrated sensitivity in managing challenging behaviour by the children and showed awareness of some of its underlying causes. The dynamic of the sibling group was significant. If one child became upset or angry with the staff group, the others were said to respond out of loyalty to their sibling, and sometimes an issue for one individual became an issue for all.

The centre had a good written policy on the management of behaviour and it was the focus of the service to challenge sensitively any unacceptable behaviour from the parents or the children. Inspectors were able to find evidence of how staff worked with the children on issues such as respect for each others property, privacy, and use of aggression.

A section on sanctions imposed was kept on each child's file. The sanctions varied from not being allowed out to play for refusing to go to school to having to stay in the evening after having a scrap with a neighbour's child. The children talked openly to inspectors about their own behaviour and how the staff handled things when they did something wrong. They felt that the operation of sanctions was fair.

Inspectors found that the one of the older children had absented herself from the centre or had stayed out longer than agreed on several occasions. (See 4.6.6.)

#### **4.6.5 Restraint**

The NAHB had a policy that all staff in its residential centres should be trained in TCI. Ten of the 12 staff in the centre were trained in TCI. It did not feature prominently in the day-to-day running of the centre, but when it did there was some confusion about its use.

In one instance a child was aggressive towards a sibling in the centre's van and for the protection of the person the child was attacking he had to be lifted off his seat and out of the vehicle. This was not recorded as a restraint as it is not an approved handling procedure under TCI. However it was an appropriate action for staff to take for the safety of all. If a child is restrained it should be recorded, irrespective if it is part of one methodology of physical restraint or not.

There was also an incident in relation to the notification of a restraint to the social worker which was recorded as having occurred but which the social worker said she had no record.

Inspectors recommend that the acting centre manager arrange for those staff who have not received TCI training to receive it as soon as possible, that those in need of refresher training receive it, that incidents where restraint is used are properly recorded and notified by the centre staff, and that the alternative care manager and the monitor carry out regular checks on the centre's use of TCI.

### **Recommendation**

#### **15. The board should ensure that training, procedures and monitoring in respect of physical restraint in the centre are in accordance with the board's policy.**

##### **4.6.6 *Absence without authority***

Within the centre's policy document unauthorised absences are defined as "an event that leads to the child being regarded as missing or outside the supervision of the parent or team members without permission or agreement".

On reading the administrative files it became clear to inspectors that the whereabouts of one of the older children were at times unknown to staff. Inspectors were seriously concerned that this child could be at risk when away from the centre without permission. The social worker was not informed of the absences, even though one absence was for a period of three days. There had not been clear communication about the fact that the young person's whereabouts were unknown even though she had permission to go to one household and telephone conversations confirmed that she was not there, nor had the vulnerabilities and situations of risk been brought to the attention of the social worker. Some of the permissions for stays with family members were granted by the centre staff and parent, and did not involve the social work team.

Inspectors are of the view that practice in the area of unauthorised absences is in need of reform, and that the staff would benefit from plans about access agreed with the social worker, and training in the assessment and management of risk. The points made about notification of significant events (4.2.6) also apply here.

Inspectors recommend that these behaviours are discussed with the social worker and the young person concerned and that the identified risks are assessed and appropriately managed by the centre staff and other relevant parties.

### **Recommendation**

#### **16. In consultation with managers and social workers the acting centre manager should review the centre's policy and procedures for unauthorised absences.**

## **4.7 Safeguarding and child protection**

### **4.7.1 Safeguarding**

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

Inspectors found a culture of openness within the centre. It was very clear from the children that if they had any concerns that they would speak to the acting centre manager. Children's rights were promoted and proactive throughout the centre. The children were involved in the day to day running of the centre and encouraged to attend the weekly meetings.

There were good recruitment practices within the centre. The acting centre manager was proactive in seeking evidence of vetting when agency workers were occasionally used.

The issue of bullying within the centre was also addressed. It was encouraging to see the parent working with staff in dealing with aggression and bullying of some children by others.

The lack of social work or monitoring visits to the children for a period of nearly four months is a serious gap in safeguarding measures.

The staff and social work teams need to develop agreed risk assessment formats for making decisions for the children when visiting and spending overnights with relatives and friends.

### **4.7.2 Child protection**

**There are systems in place in the centre to protect young people from abuse. Care staff is aware of and implement practices which are designed to protect young people in care.**

The centre had written practices and procedures in relation to child protection, but they had not been endorsed by line managers or social workers in the board. Staff had received briefing on the Children First: national guidelines for the care and protection of children. However, there was evidence that staff seemed confused about what should or should not be notified as a child protection issue.

Of particular concern is how the staff dealt with an allegation of physical assault by a staff member (see 4.4.3), later withdrawn, and how judgements were made about risk factors when a child was away from the centre (see 4.6.6).

For a short period during the earlier stages of the placement it had been arranged that there should be fortnightly meetings of all those involved in the case to discuss concerns as they arose. As key figures became absent through extended leave or other factors the meetings were postponed and the schedule was not picked up again.

Inspectors are of the view that there is a need for a review of practice under Children First. The centre staff should have a clear understanding of what needs to be referred to the social worker or notified to the child care manager, and there should be agreement

between the centre and the social work team about how judgements of risk are taken. In this centre, this has a particular significance where decisions regarding children's activities are shared between staff and the parent. The plan to hold fortnightly meetings to discuss the concerns was commendable. However, there should be contingencies to ensure that the meetings continue even when individuals are on leave.

## **Recommendations**

- 17. The board should ensure that decisions about how judgements of risk are taken are reviewed.**
- 18. The ACEO in consultation with the CCA6 child care manager should finalise the centre's draft policy and practice on safeguarding and child protection.**

### **4.8 Education**

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

Inspectors were highly impressed with the links that the centre had with the schools at which the children attended. It was encouraging to note that all the children had remained in the schools they attended before coming to live in the centre. This was important to the children at the time of admission and had provided continuity thereafter. Generally, the schools reported themselves to be happy with their contacts with the centre. One of the children in the centre attended a special school and availed of a wide range of services including a speech and language therapist, and a school social worker. The school worked closely with the centre and the parent in addressing this child's educational needs. Staff at the centre clearly valued education, and supported all the children at the centre to achieve their educational potential. The standard on education was met.

### **4.9 Health**

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

The children did not have a medical assessment on admission to care. However, it was noted by inspectors that three of the children had full medicals in June 2003. The children were registered with their own family GP.

Inspectors found that there had been confusion between the parent and the staff about the parent bringing a child to the GP without discussing this with staff. On two occasions staff found out after the event that the parent had taken one of the children to the GP. Staff and the social worker were concerned that a lack of clear communication and roles had created a situation where they were not aware of a medical concern for a child in the care of the board.

The centre staff facilitated the children in accessing other health services, and kept clear records of appointments and outcomes. Practice in relation to the administration of medication was good.

The centre staff responded sensitively to one young person's needs in respect of diet, and involved the parent in promoting healthy eating habits.

#### **4.10 Premises and safety**

**The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.**

The premises were suitable for the residential care of young people and their use was in keeping with their stated purpose. Inspectors found the staff team centre were attentive to issues of physical safety in the centre.

##### **4.10.1 Accommodation**

The centre comprised of two adjoining house integrated to provide improved accommodation. It was part of an established estate and fitted well into the area. The outside was freshly painted and blended in with the rest of the houses on the street. The back garden had scattered pieces of fencing and some trip hazards in the ground. It required tidying and some repairs in order to make it a safe place for the children to play.

There was adequate accommodation and the standard of décor was high. There was a combination of warm colours on the walls, good quality furnishings, pictures and photographs, and modern appliances in the kitchen. There were two rooms on the ground floor that allowed for space to work individually with the children or for the children to play. Those interviewed by inspectors commented on the regular smell of home cooking.

Prior to admission the children were involved in choosing their bedrooms and had a say in how they were decorated. Two of the young people shared a room. There was room for the use of the parent when staying in the centre.

##### **Recommendation**

**19. The acting manager should ensure that the back garden is made safe for play.**

##### **4.10.2 Maintenance and repairs**

The centre had an efficient system for reporting items requiring repair or maintenance. However, there were delays in getting a response from those with responsibility for maintenance. The most notable example inspectors found was that the centre's washing machine had been out of action for several weeks and during the inspection staff were taking large quantities of washing to the launderette each day.

##### **Recommendation**

**20. The board should ensure that maintenance requests in the centre are given a prompt response.**

#### ***4.10.3 Safety (including fire safety)***

The centre had an up to date health and safety statement. The centre staff worked with the children to enhance their safety awareness.

Medicines were stored in a locked cabinet in the staff bedroom. Only current medicines were stored. There was a practice of clearing out medicines once they were no longer in use.

There was an impressive nightly safety check list that is carried out by team members before retiring to bed.

Vehicles used in transporting the children were driven only by persons whose licences had been checked; and the centre's own vehicle was appropriately insured and taxed.

Inspectors received written confirmation from the fire safety officer of the Eastern Health Shared Services that the centre had adequate arrangements to guard against the risk of fire and other hazards in accordance with the regulations.

## **5. Summary of Recommendations**

- 1. The board should review the purpose and function of the centre paying particular attention to the role of parents and staff.**
- 2. The board should introduce multidisciplinary assessments and risk assessments at the time of referrals of families to the service in order to ensure that the centre can meet the needs of the children placed there.**
- 3. The board should introduce a consistent system of on-call cover for the acting centre manager**
- 4. The board should endeavour to secure qualified staff in permanent positions.**
- 5. The board should carry out a training audit and develop a plan for the staff team.**
- 6. The acting centre manager should ensure that significant notification of events is carried out in accordance with National Standards and board policy.**
- 7. The monitor should carry out regular checks to ensure that the notification of significant events in the centre is in accordance with the standard.**
- 8. Managers should ensure that the standard on keeping the register is met.**
- 9. The ACEO should review the centre's system for dealing with complaints**
- 10. The board should appoint a person from outside the immediate line management of the centre to the referrals and admissions committee.**
- 11. The board should arrange for the immediate development of full care plans for all the children and reviews of care planning should be held in compliance with regulation.**
- 12. The alternative care manager and principal social worker should ensure there is effective communication between them on issues of mutual responsibility.**
- 13. the board should ensure that children in residential care have an allocated social worker, and that there are contingency plans to cover the social worker's duties in the event of extended leave.**
- 14. The acting centre manager should introduce a key worker system appropriate to the service provided by the centre.**
- 15. The board should ensure that training, procedures and monitoring in respect of physical restraint in the centre are in accordance with the board's policy.**
- 16. In consultation with managers and social workers the acting centre manager should review the centre's policy and procedures for unauthorised absences.**
- 17. The board should ensure that decisions about how judgements of risk are taken are reviewed.**

- 18. The ACEO in consultation with the CCA6 child care manager should finalise the centre's draft policy and practice on safeguarding and child protection.**
- 19. The acting manager should ensure that the back garden is made safe for play.**
- 20. The board should ensure that maintenance requests in the centre are given a prompt response.**