

Health Information and Quality Authority Regulation Directorate

Monitoring Inspection Report on children's
statutory residential centres under the Child Care
Act, 1991



Type of centre:	Children's Residential Centre
Service Area:	The Child and Family Agency North Dublin
Centre ID:	OSV-0004176
Type of inspection:	Unannounced Full Inspection
Inspection ID	MON-0016942
Lead inspector:	Niamh Greevy
Support inspector (s):	Erin Byrne

Children's Residential Centre

About monitoring of Children's Residential Centre

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011, to inspect children's residential care services provided by the Child and Family Agency.

The Authority monitors the performance of the Child and Family Agency against the National Standards for Children's Residential Services and advises the Minister for Children and Youth Affairs and the Child and Family Agency. In order to promote quality and improve safety in the provision of children's residential centres, the Authority carries out inspections to:

- assess if the Child and Family Agency (the service provider) has all the elements in place to safeguard children
- seek assurances from service providers that they are safeguarding children by reducing serious risks
- provide service providers with the findings of inspections so that service providers develop action plans to implement safety and quality improvements
- inform the public and promote confidence through the publication of the Authority's findings.

Compliance with National Standards for Children's Residential Services

The inspection took place over the following dates and times:

From:	To:
26 January 2016 09:00	26 January 2016 18:00
27 January 2016 09:00	27 January 2016 18:30

During this inspection, inspectors made judgments against the *National Standards for Children's Residential Services*. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

The table below sets out the Standards that were inspected against on this inspection.

Standard	Judgment
Theme 1: Child - centred Services	
Standard 4: Children's Rights	Requires improvement
Theme 2: Safe & Effective Care	
Standard 5: Planning for Children and Young People	Requires improvement
Standard 6: Care of Young People	Requires improvement
Standard 7: Safeguarding and Child Protection	Meets standard
Standard 10: Premises and Safety	Requires improvement
Theme 3: Health & Development	
Standard 8: Education	Meets standard
Standard 9: Health	Significant risk identified
Theme 4: Leadership, Governance & Management	
Standard 1: Purpose and Function	Meets standard
Standard 2: Management and Staffing	Requires improvement
Standard 3: Monitoring	Meets standard

Summary of Inspection findings

The centre was a four bedroom detached bungalow located in a suburb of Dublin. The house was spacious and nicely decorated, with a large garden to the rear and ample parking at the front. The house was well served by local amenities, such as schools, shops and public transport. The centre's statement of purpose outlined that the service catered for four children between the ages of 13 and 18 years of age. At the time of the inspection, there were 4 children living in the centre.

During this inspection, inspectors met with or spoke to 3 children, 3 parents, managers and staff. Inspectors observed practices and reviewed documentation such as statutory care plans, child-in-care reviews, relevant registers, policies and procedures, children's files and staff files.

The service was found to be operating within its statement of purpose and was staffed with a stable and experienced team. Inspectors found that staff emphasised developing relationships with children and had a good understanding of the needs of the children resident in the centre. At the time of inspection the house was occupied by four children, two of whom were siblings. The service was awaiting updated plans from child in care reviews that had taken place in previous weeks. Inspectors saw that children had placement plans that informed the development of weekly plans. There was evidence that some children had contributed to their plans while other's children's wishes were not reflected in plans. Safeguarding issues were managed appropriately by the service.

Three out of four children were attending an educational placement and ongoing efforts were being made to re-engage one child in training. Children's health was well taken care of but inspectors identified significant issues around the safe management of medication.

Inspectors found that the implementation of management systems needed to be improved so that review, learning and accountability become part of everyday practice in the centre.

Inspectors found the centre to be a welcoming environment and want to thank children, families and staff for their co-operation with the inspection.

Inspection findings and judgments

Theme 1: Child - centred Services

Services for children are centred on the individual child and their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.

Inspectors found good evidence of children being at the centre of the work carried out by staff but improvements were needed to ensure that children were consistently involved in decision making. There was also evidence that complaints were responded to but systems in place did not identify when complaints were not satisfactorily resolved.

Standard 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.

Inspection Findings

Inspectors found that the rights of children were respected and promoted. There was evidence that children were aware of their rights and supported in exercising them. For example, children had accessed their records with the support of staff where they wanted to. Children had their own private space and staff respected the individual needs of the children living in the unit. There was evidence of contact between children and the advocacy service for children in care (EPIC) and one child had an appointed guardian ad litem.

Children had input into their care planning and had all attended their child in care review meetings. Inspectors found evidence of children's views being sought to inform care planning. However, improvements were needed to ensure children were consistently involved in developing their placement plans. Some children had discussions with their key worker around placement plan goals and there was evidence that staff were supporting children around achieving some of these goals. However, spaces for children's signatures were often blank and there were no records of other children having any input into their placement plan. Staff reported that they would draw up the placement plan and ask children if they wanted anything changed. One child told inspectors about their goals but inspectors did not find these goals reflected in their placement plan. This child had attended their child in care review the week before the inspection, but was unclear about how or when their goal would be achieved. This was due to the nature of the plan put in place by the social work department, based on their assessment of the family.

Inspectors found the centre had processes in place to obtain children's views around the running of the centre but found that these forums could have been used more effectively to address relationship issues amongst residents. Children were routinely

asked if there was anything they wanted to be brought up at the staff meeting and inspectors saw that these usually related to items to be bought in the grocery shopping or extending curfew. Children had regular house meetings where topics such as cleaning, pocket money, fire safety and expectations around school attendance were discussed and managers were eager that children decided on what was discussed at these meetings. However, at different times, children identified dynamics in the house that were upsetting to them and the children's meetings had not been used to help children talk about these matters and find a resolution. While group discussion is not always the best way to manage relationship issues between residents, inspectors were of the view that there was scope to use this resource to address some issues that had arisen between children. Due to a high number of absences from the centre, inspectors found that one child had not attended any children's meetings and meetings were going to be moved to another evening to facilitate another child to attend.

Inspectors found that families were not aware of their right to receive written information about their child's placement. This issue was not addressed in the centre's induction booklet and some parents reported that they were not aware that they had a right to have a copy of placement plans, monitoring or inspection reports.

While all complaints made to the centre had been responded to, systems in place did not adequately monitor the incidence and outcomes of complaints. Inspectors saw that there was a complaints log kept by the centre that was signed by the alternative care manager. Inspectors found that the service attached contact sheets to complaint records instead of using complaints documentation to track the progress of the complaint. These contact sheets were a record of the conversations that took place with people involved in the complaint. Some complaints were unclear in recording if the complainant was satisfied with the outcome of the complaint and inspectors were of the view that the volume of complaints in relation to one young person was notable and needed further attention. While the service reported that all complainants were satisfied with the outcome of complaints, inspectors spoke with two complainants who reported that while their complaints had received a response, they were dissatisfied with the outcome and felt the service didn't listen to them.

Judgment: Requires improvement

Theme 2: Safe & Effective Care

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs.

All children in the centre had either an up-to-date care plan or a recent child in care review and were awaiting the updated plan. Inspectors found evidence that children were usually involved in the care planning process but some improvements were needed in relation to this. The service met the standards in most regards under 'care of young people' (standard six) but this is not reflected in the judgement due to the service not having a separate book to record restraints, which is required under the national standards. Safeguarding issues were well managed by the centre. Health and

safety practices were found to be good but the inspection identified some areas for improvement in relation to fire safety.

Standard 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. This 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.

Inspection Findings

Inspectors found that there were effective procedures in place for admissions into the centre to ensure placements were suitable. Children in the centre were admitted in line with the unit's statement of purpose and children had pre-admission risk assessments on file to identify any risks the placement might pose to them or other young people living in the centre. These assessments reflected the needs of children in the centre and the centre manager reported that they received adequate information at the point of referral. Inspectors found evidence that controls identified to manage risks in relation to young people were implemented such as engagement in individual work, stay safe programmes and therapeutic services.

Children understood the reason for their placement in the centre and most children had regular contact with their social worker. The centre provided inspectors with a copy of their induction booklet which gave an outline of how transition into the centre worked, amenities in the area and expectations of children while living in the house. However, this guide did not provide information in relation to pets and holidays as is required by the standards.

Inspectors found that children were discharged in a planned manner, except where one child was moved suddenly due to a court order. Where children were due to leave the centre, plans were in place to work on independent living skills and to ensure there was support around educational placements. While there was a lack of certainty around the onward placement for one child, it was evident that staff were liaising with the appropriate services in relation to this.

All children in the centre had an allocated social worker and all but one child was visited in line with the regulations. It was evident that staff had highlighted the difficulties in communication with this social worker and had asked for visits to be made to the centre.

Children's needs were appropriately assessed and actions were identified in care plans to address the identified needs. Three children had child in care reviews in the two weeks prior to the inspection and as a result up-to-date plans were not available for these children. Inspectors found that care plans were comprehensive and addressed a wide range of children's needs, although the plans on file for these three children no longer contained relevant information. Inspectors saw evidence that a number of actions in care plans were completed. However, minutes of child in care reviews were

not on file so it was not possible for inspectors to see if reviews assessed the effectiveness of the previous plan or took developments into account. Inspectors saw that an appropriate range of people were involved in developing care plans.

Children had regular contact with their families in line with their wishes and this contact was supported by the centre. Two children in the centre were siblings and where children were not placed in their own community, the centre supported these children to maintain links with their community through attendance at school, social activities and health services. Families reported to inspectors that they were kept informed and had regular meetings with the manager to discuss the care provided to their child. Children's relationships with their peers were supported and individual work was done with some children depending on their needs.

Inspectors found that children had good relationships with staff and key working sessions were used to support children around any areas of difficulty in their lives. Where needed, children were referred to appropriate therapeutic and mental health services. Some children were being supported by staff to develop independent living skills and were engaging in key working sessions in areas such as money management, staying safe and mental health and wellbeing. It was also clear that staff were supporting some children in relation to their wishes around further education and follow-on placements.

The centre was not meeting the needs of one child in their care who spent most of their time outside the centre. However, continuing efforts were made by the staff team to engage with the young person, support them with their transition to adulthood, provide emotional support and ensure the safety of the child through regular phone and face-to-face contact. While this situation was far from ideal, the centre played an important role in ensuring the safety of and providing support to this young person until a more suitable onward placement was found.

Inspectors saw that children's records were well organised but some were missing necessary documentation. Files were stored in a secure cabinet and there was a system in place to archive old files. Inspectors found evidence that documentation had been reviewed to ensure that it was signed by the appropriate staff but inspectors did not find that records were reviewed for the purpose of safety and quality of care practices. Some files did not contain up-to-date voluntary care agreements.

Judgment: Requires improvement

Standard 6: Care of Young People

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. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

Inspection Findings

Inspectors found evidence that children were supported to pursue their interests and

their achievements were recognised and celebrated. There were no records around meal planning but inspectors saw that work was being done with some children around healthy eating and healthy food was available to children during the days of inspection. Some children cooked for themselves and some children had regular visits from their family where they cooked and ate together. Children's needs in relation to identity and culture were supported and respected.

Inspectors saw that staff were making considerable efforts to support children who presented with behaviour that challenged. Plans were in place to manage incidences where children were absent from the centre without permission. Inspectors found that key workers focused on developing and maintaining good relationships with children and this was important for supporting children and keeping them safe. Some incentives were in place to encourage children to behave well.

The number of restraints used in the centre was low but there was no book to record restraints and staff relied solely on significant event forms. However, the lack of a central record of restraints impacted on the ability to monitor the use of restraint. Inspectors found that an intervention was used to break up a fight. As a restraint was not used, the incident was not identified as a restrictive practice by the centre manager. The intervention was used appropriately but it is essential for restrictive practices to be identified as such, in order to be able to monitor and review them appropriately.

Judgment: Requires improvement

Standard 7: Safeguarding and Child Protection

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.

Inspection Findings

Staff were trained in Children First (2011) and knew how to manage child protection concerns. There was a designated child protection officer and all concerns in the centre had been managed appropriately. Inspectors identified that it was difficult to track the outcome of concerns in some circumstances due to the filing system in place but concerns had been followed up or were in the process of being followed up. Managers advised that they reviewed child protection concerns approximately every six weeks to ensure that they were being progressed but this was not recorded anywhere on files. Staff were aware of who they could contact if they had any serious concerns.

Judgment: Meets standard

Standard 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 (Placement of Children in Residential Care) Regulations, 1995.

Inspection Findings

Inspectors found that the design and layout of the centre was suitable to the needs of children. Work was being carried out to replace the heating system. Inspectors noted the kitchen was in need of repair and were informed that further work was planned to update the kitchen and décor. Inspectors reviewed maintenance records and found there was prompt follow-up on maintenance issues.

Since the last inspection, there was a period of two months where two siblings shared a room. While this decision was made in order to cause minimum disruption in the young people's lives, the standards state clearly that young people should have a room to themselves and the statement of purpose in place did not reflect that the centre would permit siblings to share a room in exceptional circumstances. As one sibling had moved on, this was not an issue at the time of inspection.

The centre used two vehicles which inspectors found were in good repair and were taxed and insured.

Health and safety risk assessments were in place and were of good quality but some improvements were needed in relation to the recording systems. The local health and safety statement was signed by staff. Regular checks were in place such as testing emergency lights, exit routes, checking the condition of furniture and nightly checks such as closing windows. However, where checks were missed or where issues were identified, the documentation did not outline the action taken in response. Staff informed inspectors that in these circumstances, matters were followed up with the staff in question but records did not reflect this. Records showed that where hazards such as torn upholstery was observed, this was promptly rectified.

Inspectors found that fire drills took place regularly but some areas for improvement in the area of fire safety were identified. The service noted in their last action plan that fire drills would be scheduled for new admissions to the centre and inspectors found evidence of this happening on this inspection. Staff also had up-to-date fire training. Inspectors found that fire records did not identify the names of residents or staff who took part in drills, the obstacles encountered during drills or a response to how these would be addressed. Fire extinguishers were serviced on the day of inspection after a fifteen month period, three months after they were due to be serviced. Inspectors saw evidence that this issue was identified by the health and safety officer in the centre, who made efforts to have this issue resolved earlier. Inspectors observed that the front door was locked at all times which could impede a timely escape in the event of an emergency. The decision to lock the door was not risk assessed and inspectors did not find any evidence that the decision had been reviewed.

Judgment: Requires improvement

Theme 3: Health & Development

The health and development needs of children are assessed and arrangements are in place to meet the assessed needs. Children's educational needs are given high priority to support them to achieve at school and access education or training in adult life.

The centre encouraged and supported children to attend school. Where one child was not in training or education, the centre had made efforts to re-engage them. Children's healthcare needs were well-cared for and staff were responsive to mental health concerns. However, inspectors identified significant issues in relation to the management of medication.

Standard 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.

Inspection Findings

Inspectors found that education was highly valued in the centre and staff encouraged and supported children to attend school. Three out of four children were attending secondary school. One child did not have an education placement but there was evidence from records that staff had and continued to make efforts to engage the child in training that was of interest to them. However, despite these efforts, the child was not engaging in a programme. Where children were placed outside of their community, the centre supported them to remain in their school placement, thereby being in a position to maintain friendships after their transition to care. Where children needed additional supports, they were attending grinds and children were offered incentives to continue to engage in school. The centre had also arranged for one young person to go to the gaelteacht during summer months. Inspectors found there was good communication between the centre and schools, and children were supported to move on to third level education.

Judgment: Meets standard

Standard 9: Health

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

Inspection Findings

Inspectors found that children's health was well taken care of but recording in relation to allergies and medication management was not safe. Children had timely access to their own GP and other services that were identified for them, such as mental health services. A healthy lifestyle was promoted by the centre, although one child in the centre smoked cigarettes. Medical records gave a clear indication of the health problems that were arising for individual children and there was evidence on files of medical issues being followed up promptly. However, files did not give a clear indication of where children had allergies or intolerances to particular medication. While it was not possible to get immunisation records for some children, other children did not have their immunisation records on file. In addition to this, significant issues were identified in respect of medication management systems. For example, records did not outline important prescription information such as the dosage instructions and if medication was not given, administration records did not say why this happened. In addition to this, inspectors found discrepancies in places between the number of tablets in stock

when the medication was last administered and the number of tablets returned to the pharmacy. These systems were not safe and could not support managers to be assured that the correct medication was being administered at the right times.

Judgment: Significant risk identified

Theme 4: Leadership, Governance & Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed. The system is subject to a rigorous quality assurance system and is well monitored.

Inspectors found that while management systems were in place, they were not being implemented in a way that was effective in improving outcomes for children. Risk management and oversight systems needed improvement, and managers in the unit needed additional training in the area of risk. The centre had a stable staff team in place which provided consistency for children and apart from two staff who remained unqualified, staff had received appropriate training to support them in their role. The centre was visited by a monitoring officer and this report was issued in November 2015.

Standard 1: Purpose and Function

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

Inspection Findings

The statement of purpose for the centre outlined that the centre catered for four children between the ages of 13 and 18 years, with the ultimate goal of encouraging young people to achieve semi-independent or independent living status. Inspectors found the document to be in a form that was accessible to the children living in the unit. While the document explained that the centre adhered to Tusla policies and procedures, it did not outline how these policies could be made available to young people and their families, as per the national standards. At the time of inspection, inspectors found the service to be operating in line with its statement of purpose.

Judgment: Meets standard

Standard 2: Management and Staffing

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

Inspection Findings

The centre was managed by a suitably experienced and qualified manager and deputy manager. Both managers were familiar with the day-to-day running of the service and

the needs of the children in their care. The centre manager was supervised by an alternative care manager, who in turn reported to a regional manager. The regional manager reported to the acting national director for children's residential services.

Inspectors reviewed local and regional management meeting minutes where they were available. Inspectors found that the local management meetings took place almost every two months and a range of issues were discussed relating to finances, staffing, training and significant event notifications. However, decisions and tasks from this meeting were not clearly recorded or assigned to a responsible person.

Inspectors did not find evidence that learning from the significant event review group (SERG) was being implemented in the centre. The purpose of SERG meetings is to learn from significant events in order to improve practice. Dublin North East held regular SERG meetings where significant event notifications were discussed by the panel which is made up of local managers, the alternative care manager and sometimes, a monitoring officer. It was unclear what criteria were used to determine which significant events warranted review by the SERG and the centre manager reported that sometimes they made the decision while other times it was discussed at team meetings. Inspectors did not find any evidence in team meeting minutes of discussions of this nature. Inspectors saw clear instructions that all complaints needed to be automatically referred to the SERG but there was no evidence in SERG minutes that complaints were discussed. This issue was not identified when complaints were signed by the alternative care manager. In relation to sharing the learning from SERG meetings, the centre manager advised this was done through team meetings. Inspectors only saw evidence in one team meeting of findings of the SERG being communicated in this forum and there was evidence that recommendations made by the SERG in relation to the recording of significant events had not been implemented in the centre.

Inspectors reviewed the records of supervision provided to the centre manager and found them to be of good quality. The regularity of supervision was in line with policy, the content of the discussion was focused and there was evidence of good follow through on issues. An area for improvement was to clearly record decisions, the person responsible and timeframes for completion.

Inspectors found the centre had a register of children which had all the required information and notifications of significant events were reported to the appropriate people in a timely way. Inspectors also reviewed financial records for centre and found the service were clearly recording how money was being spent.

Individual risk management relating to children was effective but risk management at the level of centre risks needed attention. Inspectors found that good quality risk assessments had been routinely completed in relation to children's care and day-to-day situations being managed by staff. In addition to this, inspectors found that the risk assessments relating to health and safety issues were of good quality and one assessment contained on the risk register relating to bullying was very comprehensive. There was also evidence that the register had been reviewed and a decision was made for risks assessments to be removed from or remain on the register, as appropriate. However, the risk register did not show when additional control measures would be implemented by, who was responsible for implementing the identified control measures, and risk assessments were not signed, dated or risk rated. In one risk assessment, it

was unclear what exactly the control measures in place were there to mitigate against and where additional control measures should be outlined, a further risk was recorded.

Systems around the management of risk were unclear and not all risks were identified by the centre. Inspectors asked the centre manager about risk management systems and it was unclear what system was in place to determine the threshold at which risks are placed on the risk register. Inspectors also identified some risks were not on the risk register, such as the risk to the safety of staff and children given that the fire extinguishers had not been serviced in fifteen months, up to the day of inspection. Inspectors asked about training for managers around risk management and were advised that the centre manager had recently asked for training in this area. The centre manager also advised that they were due to get support from another manager with knowledge in the area of risk management.

Management systems were in need of improvement to ensure the service was safe and effective. Inspectors found that the systems of oversight in place were designed to ignore errors rather than ensure effectiveness. For example, the system around health and safety checks did not reflect that the health and safety officer was ensuring that checks were completed, and following up with staff where they were not completed. Instead, where there were gaps in checks, these were signed off. In relation to infection prevention and control, staff reported that there was a schedule of cleaning in place in the centre. However, inspectors found that this rota was not consistently filled in. The rota was started on 24/08/2015 but there was no space to fill in what cleaning tasks had been completed in subsequent weeks. Although cleaning was discussed in a number of team meetings, inspectors did not find evidence that rotas had been checked to ensure that the tasks had been completed as and when agreed. Inspectors found the centre was well maintained except for a small number of areas that needed less regular cleaning. However, systems in place did not ensure that these were clean on the day of inspection.

Oversight of significant event notifications was another system that needed review. Managers reported to inspectors that significant event notifications were reviewed approximately every six weeks. However, the only evidence of review of significant events were sticky notes that were attached to the front of a number of notifications that indicated when signatures were missing. Any commentary from managers in relation to significant event notifications should be recorded permanently on the form and should also include critique in relation to the content of the form, such as identifying and commenting on the use of restrictive practices, risk management and behaviour management, and not be limited to whether the form is signed or not.

While health and safety, medication and supervision audits were in place, audits were not always effective in improving practice. For example, medication was checked weekly but this was limited to checking the stock of medication and that it was in date. However, when the numbers of tablets in the medication cabinet didn't match the number on the medication records, this was signed off by staff without further exploration. Audits of supervision were conducted in 2014 and 2015 which checked that the frequency of supervision was in line with policy and that records were stored securely. However, in 2014 the supervision audit identified professional development was not adequately discussed and in 2015, the same issues were pointed out. In addition to this, both audits did not address the impact supervision had on the quality

of care provided to children. Inspectors also identified areas where the introduction of audits could improve the quality of the service such as file audits to ensure that relevant documents are contained on file, that plans are up-to-date and improve outcomes for children.

Inspectors reviewed team meeting minutes and found that these meetings could be used more effectively. Team meetings usually took place weekly, were in the region of three hours duration and were mainly used to give a narrative of the past week of the children's lives. Other issues discussed in team meetings were the roster, annual leave, shopping, petty cash and bullying. Some meetings were used well to refresh the staff team's knowledge of the standards, or provide information around eligibility for aftercare and the forthcoming Aftercare Bill. Significant event notifications were sometimes discussed but for information purposes rather than any analysis of the incident, how it was managed or any impact on the individual crisis management plan. In one team meeting there was feedback from learning from the significant event review group (SERG). The function of the SERG will be discussed further below. While team meetings helped staff have a full picture of how children were getting on, the opportunity to share learning around the management of incidences, identify and address current risks and improve the quality of communication to and from senior management were lost. Despite the centre manager and/or deputy manager attending local and regional management meetings, there was no evidence that the decisions from these meetings were fed back to the staff team.

Inspectors reviewed supervision records and found they were of mixed quality. Supervision took place regularly but there was inconsistency in the focus of supervision depending on the supervisor and the quality of records was varied. Inspectors found that some records were very clear in outlining the main points discussed, provided accountability and evidence of management oversight. However, others described a narrative and were unspecific about the central issues. Across all records, inspectors found that the template for supervision was being under utilised as records did not habitually detail timeframes or a person responsible for actions and there was a lack of follow through on previous decisions made. Inspectors also agreed with the findings of the supervision audit that professional development was not discussed consistently enough.

Most staff working in the centre had been in the position for ten years or more. Inspectors reviewed a number of staff files including that of staff who had begun working there since the last inspection. Inspectors found the induction process to be comprehensive. Older staff files were missing documents such as contracts and job descriptions but efforts were made to retrospectively verify older references. Newer staff files contained relevant documents apart from a staff member's job description.

There was a consistent staff team in place and all but two staff were appropriately qualified. Inspectors discussed this with the centre manager who advised that they hoped that one of these staff members would obtain a qualification but they did not expect the second person to. Inspectors noted that the number of unqualified staff had fallen since the last inspection but managers needed to consider reviewing any impact of unqualified staff on the quality of the service and determine if there were any mitigating actions that could be taken. Inspectors found that the stability and experience of the team provided consistency and stability to children.

Staff were trained appropriately in core areas such as manual handling, first aid and behaviour management. The training needs analysis in place had identified appropriate areas for further training such as cultural awareness and mental health, which were completed in 2015 and a further training needs analysis was in place to inform the training plan for 2016.

Judgment: Requires improvement

Standard 3: Monitoring

The Health Service Executive, 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 Service Executive to monitor statutory and non-statutory children's residential centres.

Inspection Findings

The monitoring officer had visited the centre and issued a report in November 2015. This report was accessible to inspectors in advance of the inspection. Inspectors found that the service had made progress in relation to the recommendations of this monitoring report. Inspectors spoke with the monitoring officer who advised that the service are responsive to their involvement and maintained good communication with their office.

Judgment: Meets standard