



**SOCIAL SERVICES  
INSPECTORATE**

**BALLYDOWD SPECIAL CARE UNIT**

**SOUTH WESTERN AREA HEALTH BOARD**

**INSPECTION ID NUMBER: 114**

**Publication Date: 21st March 2005**

**SSI Inspection Period: 6**

**Centre ID Number: 101**

ADDRESS: Social Services Inspectorate, Floor 3, 94 St. Stephens Green, Dublin 2

PHONE: 01-4180588      FAX: 01-4180829

WEB: [www.issi.ie](http://www.issi.ie)

- 1 Executive Summary**
- 2 Introduction**
  - 2.1 Methodology*
  - 2.2 Acknowledgements*
- 3 Setting the scene: the unit background and its population**
  - 3.1 Background*
  - 3.2 Details of current and previous placements*
  - 3.3 Management Structure*
- 4 Standards: the findings**
  - 4.1 Purpose and function**
    - 4.1.1 Role of unit*
    - 4.1.2 Statement of purpose and function*
  - 4.2 Management and staffing**
    - 4.2.1 Staffing*
    - 4.2.2 Staff checks*
    - 4.2.3 Length of service of staff*
    - 4.2.4 Staff rota*
    - 4.2.5 Qualifications of staff*
    - 4.2.6 Staff support and supervision*
    - 4.2.7 Staff training and development*
    - 4.2.8 Unit management*
    - 4.2.9 Monitoring*
  - 4.3 Planning for young people**
    - 4.3.1 Referral and placement of young people*
    - 4.3.2 Care plans*
    - 4.3.3 Reviews*
    - 4.3.4 Contact with families*
    - 4.3.5 Legal and court work*
    - 4.3.6 Supervision and visiting of young people*
    - 4.3.7 Preparation for moving on*
    - 4.3.8 Emotional and specialist support*
    - 4.3.9 Young people's case files*
  - 4.4 Care of young people**
    - 4.4.1 Relationships between staff and young people*
    - 4.4.2 Quality of care*
    - 4.4.3 Rights of young people*
      - 4.4.3.1 Access to information*
      - 4.4.3.2 Consultation*
      - 4.4.3.3 Complaints*
    - 4.4.4 Discipline*
      - 4.4.4.1 Promoting good order*
      - 4.4.4.2 Restraint and single separation*

- 4.4.4.3 *Unauthorised absences*
- 4.4.5 *Safeguarding and child protection*
- 4.4.6 *Health*
- 4.4.7 *Privacy, dignity and individuality*
- 4.4.8 *Aspects of daily living*
- 4.4.9 *Personal appearance*
- 4.4.10 *Leisure activities*

**4.5 Premises, safety and security**

- 4.5.1 *Risk assessment*
- 4.5.2 *Location and design*
- 4.5.3 *Accommodation – general*
- 4.5.4 *Accommodation for individual young people*
- 4.5.5 *Maintenance and repairs*
- 4.5.6 *Safety and fire precautions*
- 4.5.7 *Security*
- 4.5.8 *Insurance*

**4.6 Education**

- 4.6.1 *Attainment and progress*
- 4.6.2 *Attitudes, behaviour and personal development*
- 4.6.3 *Attendance*
- 4.6.4 *Quality of education provided*
- 4.6.5 *Curriculum*
- 4.6.6 *Support, guidance and welfare*
- 4.6.7 *The educational management of the unit*
  - 4.6.7.1 *Management and leadership*
  - 4.6.7.2 *Staffing accommodation and learning resources*
  - 4.6.7.3 *Efficiency of unit*

**5 Summary of recommendations**

## **1. Executive Summary**

The Social Service Inspectorate (SSI) carried out the fourth annual inspection of Ballydowd Special Care Unit (SCU) in October 2004, under the provisions of Section 69(2) of the Child Care Act 1991, which provides for the inspection of the social service function of health boards.

Ballydowd is a national purpose-built secure residential facility, managed by the South Western Area Health Board (SWAHB), known after 1st January 2005 as the Health Services Executive South Western Area (HSESWA) to care for up to 18 children and young people who are detained by a court order for their own care and protection. At the time the inspection was announced there were twelve young people referred by five health boards resident in the facility. There was no waiting list. The unit comprised six buildings in an enclosed campus, three accommodation units, an administration unit, an education unit and a gymnasium, all surrounded by a high fence. Each of the young people had an en-suite bedroom.

The twelve young people were made up of six boys and six girls. They ranged in age from 12 to 17 years, and had been in the unit from 2.5 to 7 months at the time of the inspection. Their previous care histories showed a pattern of multiple placements. While two young people had only one previous placement, one had 12 previous residential placements, and the others averaged four placements each.

The unit was managed and staffed by a total of 76 care staff, including five management posts which were filled by personnel in acting positions. The post of overall manager had been filled by five different people over the four years prior to the inspection, and although inspectors found staff morale to be good, several expressed anxieties regarding management stability. Inspectors recommended the board put stable management structures in place as a priority.

The staff group, unusually, comprised slightly more male than female personnel. Eleven of the staff group had a qualification in social care; a further twenty-five had qualifications in a range of areas from psychology to economics. Eight staff were seconded by the board to relevant courses in social care. All staff, including ancillary and agency had a garda clearance, however, there were only two references in place for the majority of staff. The DoHC require that all staff should have three references. Inspectors learnt that all staff recruited subsequent to this inspection had both garda clearance and three references.

Team meetings were viewed as providing positive opportunities to make critical assessments of practice and put forward constructive suggestions. Previous inspection reports had recommended a programme of formal regular supervision for staff. During the year prior to the inspection there had been some improvement but gaps remained, in some cases up to five months between supervision meetings. Given the complex and demanding nature of the work undertaken in a SCU and the need for a high degree of support and accountability, it is imperative that the policy on supervision is put into practice and, as a matter of priority, that all staff receive regular formal supervision. Despite this, staff were positive about the support they received from colleagues and managers. Two external staff consultants were available to managers and staff for team meetings and one-to-one sessions which all found invaluable.

The board had appointed an external monitoring officer who visited regularly. Some visits were announced and others unannounced. He supplied written reports of his findings with

recommendations to the Assistant Chief Executive Officer (ACEO) (Children's Services), SWAHB and the acting centre manager. Inspectors found that most of the recommendations made by the monitoring officer had been implemented.

In the period since the previous inspection (March 2003 and October 2004) there had been 38 admissions (23 girls and 15 boys) to the unit. In the same period 34 young people were discharged, - 11 to high support units, and 15 to children's residential centres. Five returned to the care of their parents, two to a detention facility following criminal proceedings, and one to a relative foster placement.

Referring social workers outlined delays between making a referral to the Ballydowd admissions committee and receiving a final response, and suggested that, in addition to the written referral request, an oral presentation on their part would expedite the process. Social workers visited children and young people within the statutory requirements and in all cases had prepared care plans. Inspectors examined relevant social work files and found that care planning was of a high standard and was reviewed regularly. The young people by and large knew why they were detained and what was required of them to be discharged.

All the young people had independent legal representation and ten of the twelve had a guardian-ad-litem. Social workers and guardians by and large had positive comments about the care of the young people, however, both groups expressed dissatisfaction about the lack of prompt notification of information to them in defined instances, such as complaints, unauthorised absences and allegations of a child protection nature.

Young people had access to appropriate specialist services external to the centre. However, several social workers and guardians were concerned that there were so few internal therapeutic services available to the unit. There had been inconsistency in the way in which primary health care was made available to the young people, but at the time of the inspection the ACEO of the SWAHB confirmed that he had contracted a local GP practice to deliver health care to the unit in a way that would provide greater consistency and choice of a male or female doctor.

Inspectors noted the attention and care paid by a dedicated staff in the day-to-day routines of the young people including consulting with them about meals and activities, dealing sensitively and creatively with issues as they emerged, and planning outings where possible. The staff team took great interest in encouraging the talents of the young people in areas such as music and art. Families were encouraged to visit and keep contact, and parents interviewed by inspectors were, in general, very positive about the care their children were receiving. Inspectors commend the staff team for their partnership approach to parental involvement in the young people's lives.

While inspectors found that young people were consulted on a range of areas, they found gaps in access to information and complaints. A children's booklet had been prepared outlining the right to access to information, however, several of the children said they had not seen it. The unit's policy did not outline the right to access information sufficiently. The information on complaints in the booklet did not distinguish sufficiently between complaints and allegations of a child protection nature although inspectors were satisfied that complaints made were addressed. Inspectors also advised centre management to revise its practice on the timing of notification to social workers where child protection concerns were passed on to the appropriate social work department in line with Children First.

In the area of management of behaviour, inspectors found the managers and staff needed to be ever vigilant to ensure best practice, especially when working with young people who presented extremely challenging behaviour. Since the previous inspection, there had been 103 physical restraints in relation to the young people in the SCU, and inspectors advise that managers vigilantly monitor its use to ensure it is used only in line with best practice and recorded meticulously as required by Child Care (Special Care) Regulations 2004. Inspectors were concerned that single separation of young people was being used as a method of general management of behaviour, and noted that, where there were only two young people in a unit the single separation of one had a similar impact on the other through the isolation it entailed. In the period since the last inspection there had been 50 unauthorised absences undertaken by six young people. Managers were advised to review the procedure following voluntary return to the unit.

Inspectors found that the standard on education was well met. There was a full-time principal, four teachers, and part-time teachers as required. All the young people attended school full-time. Eleven of young people attended Ballydowd special school and one young person attended a special school in the community. Eight were completing Further Education and Training Awards Council (FETAC) modules at the time of inspection.

Inspectors noted the positive comments made by the young people about their teachers, and commend the school for the innovative and responsive way they have dealt with the young people's educational needs.

The acting senior manager showed inspectors evidence of compliance with fire, safety and insurance requirements.

## **2. Introduction**

The Social Services Inspectorate (SSI) carried out the inspection of Ballydowd Special Care Unit (SCU) under the provisions of Section 69(2) of the Child Care Act, 1991, which provides authority for the inspection of the social service function of health boards including children's residential centres. In line with SSI policy of inspecting Special Care Units where young people are detained annually, this was the fourth inspection of Ballydowd since it opened in September 2000. The centre was inspected against the National Special Care Standards. The inspection took place over six days from the 28<sup>th</sup> September – 7<sup>th</sup> of October 2004, and on 20th October 2004. The lead inspector was Kieran O'Connor and Michael McNamara was support inspector. Michèle Clarke, Chief Inspector, joined them on one occasion in order to interview three of the girls.

### **2.1 Methodology**

Inspectors had access to a range of documentation including:

- The unit's statements of policies and procedures,
- The young people's care files,
- The young people's social work files,
- Administrative and recording systems,
- Census forms on young people,
- Census forms on staff members,
- Staff supervision records,
- Questionnaires from parents, social workers and guardians-ad-litem,
- A sample of personnel files,

- The staff rota,
- The unit's health and safety statement,
- The unit's fire certificates,
- Complaints record since last inspection,
- Sanctions record since last inspection,
- Unauthorised absences record since last inspection.

Inspectors interviewed the acting senior manager, the acting deputy senior manager, three unit managers, seven staff members, the health board's external monitoring officer, twelve social workers and three social work team leaders, the school principal, four parents, one grandparent, the unit's director of clinical services, an external consultant, two solicitors representing six of the young people, and the Assistant Chief Executive Officer (ACEO) (Children and Families Services) of the South Western Area Health Board (SWAHB).

Seven of the young people were interviewed. Guardians-ad-litem for eight of the young people were also interviewed.

## **2.2 Acknowledgements**

Inspectors wish to acknowledge the co-operation of the young people, their parents, manager and staff in the unit, health board managers and other professionals.

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

### **3.1 Background**

Ballydowd Special Care Unit (SCU) is a purpose-built secure residential facility which opened in September 2000 to cater for the needs of young people with serious emotional and behavioural problems detained by a court order. It was established to provide a safe and secure environment where boys and girls, aged between eleven and seventeen years on admission, deemed at risk to themselves, could be helped to develop according to their individual needs. It is a national facility, managed by the South Western Area Health Board (SWAHB) known after 1st January 2005 as the Health Services Executive South Western Area (HSESWA). The campus consists of three residential units with a total capacity for eighteen young people. At the time of the inspection the service was not operating to its full capacity as there were only twelve young people residing in the unit. There was no waiting list. There was also an educational block, an administrative block, and a gymnasium and fitness suite. Inspectors found that suitable policies and practices were in place. Operational policies and procedures prepared by managers covered all aspects of care in the unit. They were comprehensive and well-considered.

Staff interviewed by inspectors were by and large well informed in relation to policies, practices and rules of the unit. There were procedures in place for informing young people, parents, guardians, guardians-ad-litem or any other person with a bona fide interest in the unit, about child care practices. The unit had two booklets outlining their care practices, one for young people and one for parents. Some of the young people were not aware of the booklet, therefore arrangements should be made to ensure that they automatically receive it on admission. In addition, appropriate procedures to ensure that the right to information by the child, parents, guardian, guardian-ad-litem or any other person with a bona fide interest in the young people needs to be further developed in accordance with the provisions of the Freedom of Information Act 1997, and the requirements of the National Standards for Special Care Units.

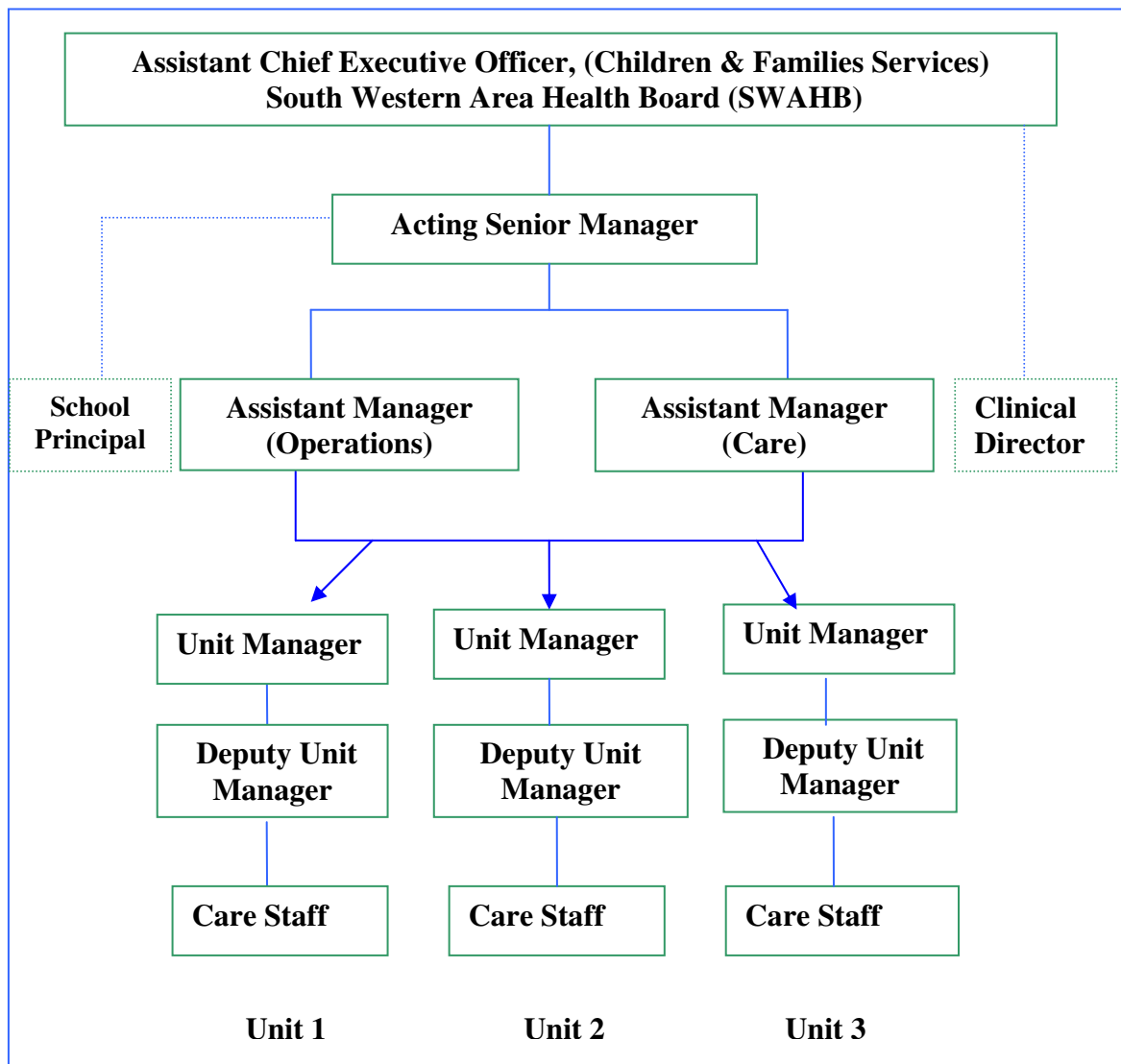
### 3.2 *Details of current and previous placements*

<i>Young Person</i>	<i>Age</i>	<i>Care Status</i>	<i>Length of time in unit</i>	<i>Previous Placements</i>
1	13 years	High Court Order	2.5 months	1 residential care.
2	12 years	High Court Order	5 months	1 foster care, 1 relative, foster care.
3	15 years	High Court Order	2 months	1 residential care, 2 high support, 2 detention
4	12 years	High Court Order	3 months	3 residential care
5	15 years	High Court Order	2 months	1 high support.
6	17 years	High Court Order	5 months	3 foster care, 2 residential care
7	15 years	High Court Order	3 months	1 foster care, 1 residential care
8	14 years	High Court Order	7 months	1 relative foster care, 4 residential care
9	15 years	High Court Order	3 months	12 residential care
10	15 years	High Court Order	3 months	3 residential care, 1 foster care
11	15 years	High Court Order	3 months	1 foster care, 3 residential care, 2 high support
12	14 years	High Court Order	6 months	1 residential, 1 high support, 2 detention

The geographical location of the young people's board of origin reflected Ballydowd's national remit. Five of the young people were referred from the SWAHB, three from the Northern Area Health Board (NAHB), two from the North Eastern Health Board (NEHB), one from the South Eastern Health Board (SEHB), and one from the Midland Health Board (MHB).

### 3.3 *Management structure*

Ballydowd SCU situated within the South Western Area Health Board, and is managed by that area on behalf of the other health boards. The assistant chief executive (operations) has specific responsibility for Ballydowd. He chaired a management advisory group whose function was to offer general advice on the policies and procedures in operation in Ballydowd Special Care Unit. The group, which included senior professionals working for the board and an independent non-health board member, did not have an executive function. A principle and four full-time teachers staff the school. There is also a clinical director of services who is available as required by Ballydowd. Amongst other things she advises staff in relation to the professional service requirements of the young people such as speech therapy, counselling or any specialist services. She also acts as a consultant to the staff team in the management of the young people and their needs. The management structure is shown in the table below.



#### 4. Standards: the findings

##### 4.1 Purpose and Function

##### 4.1.1 Role of unit

**The unit's role in relation to the wider child care services (including regional and national) is clear and set out by the Health Board or Area Health Authority.**

Ballydowd Special Care Unit (SCU) was established to provide a safe and secure environment where up to eighteen boys and girls with emotional and behavioural difficulties aged between eleven and seventeen years on admission deemed at risk to themselves could be helped to develop according to their individual needs. It is a national facility, managed by the South Western Area Health Board (SWAHB).

#### 4.1.2 *Statement of purpose and function*

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

A written statement of purpose and function stated that Ballydowd SCU provides for the detention by order the High Court of young people aged between eleven and seventeen on admission, both male and female, for the shortest time possible so that they can be helped to develop physically, socially and educationally according to their needs. It recognised that while the element of security was important, it does not override the ethos and requirements of good child care practice and the primacy of therapeutic relationships. It further stated that the purpose of Ballydowd SCU was to restrict the liberty of young people in order to provide them with a safe, caring and controlled environment in which to address their needs so that they can return to their community as soon as possible. The policy document now needs to acknowledge that with the implementation of section 23(b) of the Children Act, 2001, admission to the unit will in future be by application to the District Court for Special Care Orders and inspectors acknowledge that at the time of inspection part 11 and 111 of the Children Act 2001 had not commenced and some aspects of the review depends on its implementation.

Regulation 4 of the Child Care (Special Care) Regulations, 2004 requires that *a health board shall satisfy itself in respect of each unit that appropriate and suitable care practices and operational policies are in place, having regard to the number of children residing in the unit and the nature of their needs*; A written set of operational policies and procedures informed practice in the centre. Centre staff showed a clear understanding of these policies. Care practices were under the continual supervision of the centre managers and the board's monitoring officer. In line with the requirements of the special care regulations an information booklet was available to the young people. There was also a booklet developed specifically for the young people's parents outlining operational policies and practices.

#### 4.2 *Management and staffing*

**There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and meet the needs of the young people.**

##### 4.2.1 *Staffing*

There were seventy- six care staff in the SCU out of a total of eighty nine full-time posts. These consisted of three senior management posts, six accommodation unit managers, sixty six care staff of whom thirteen were shift co-ordinators, three administrators, three cooks, five general assistants and three housekeepers. The senior manager and two assistant senior managers are responsible for the overall operation of the centre. Each unit has its own unit manager and deputy unit manager and thirteen shift co-ordinators. They managed a total of fifty-three care staff. The acting senior manager reported to the assistant chief executive officer. Five of the managers were in acting positions. Inspectors were informed that in the past four years the manager of Ballydowd has changed on five different occasions. Several of the staff team were concerned about the uncertainty about who would be managing the service into the future. Because of the frequency of senior management changes, some professionals external to the centre were unclear who had overall responsibility for the day-to-day management of Ballydowd. At the time of the inspection,

inspectors were told by the board that a process had commenced whereby these would become permanent.

Although inspectors found that staff morale was generally high, the uncertainty around the permanency of management posts has the potential to cause instability and accordingly recommend that this issue be dealt with as soon as possible.

The average age of the staff was 24 years six months, and the average length of service in the SCU was one year ten months. The gender balance in the staff group was forty men and thirty-six women.

Eleven of the staff had qualifications in child care, and twenty-five of the rest of the staff group had a wide range of qualifications in subjects as demonstrated in the chart below such as: behavioural science, counselling, criminology, early childhood development, economics, forensic psychiatric nursing, health services management, psychology, public administration, social work, sociology, and youth and community development. Fifteen were graduates from other countries. The board supported eight staff members attending college, and had recruited a further two staff in the qualifying year of their social care courses.

**Employment Status, Qualifications and Length of Service of Staff – October 2004**

	<i>Staff</i>	<i>Hours</i>	<i>Employment Status</i>	<i>Qualification</i>	<i>Length of service in SCU</i>
#1	Acting Senior Manager	33.75	Full-time Permanent	Diploma in Social Care Diploma in Forensic Psychiatric Nursing	4 years 1 month
#2	Acting Assistant Senior Manager	33.75	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	9 months
#3	Unit Manager	33.75	Full-time Permanent	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	4 years
#4	Unit Manager	33.75	Full-time Permanent	BSc Psychology	1 year 8 months
#5	Acting Unit Manager	33.75	Full-time Permanent	MSc Psychology (Canada)	1 year 6 months
#6	Deputy Unit Manager	33.75	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	2 years 5 months
#7	Deputy Unit Manager	33.75	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	1 year 4 months
#8	Acting Deputy Unit Manager	39	Full-time Permanent	No Qualification	3 years 5 months
#9	Acting Deputy Unit Manager	33.75	Full-time Permanent	No Qualification	1 year 7 months
#10	Team Co-ordinator	39	Full-time Permanent	No Qualification	4 years 3 months
#11	Team Co-ordinator	39	Full-time Permanent	Diploma in Human Services Management (UK)	4 years 2 months
#12	Team Co-ordinator	39	Full-time Permanent	Diploma in Sports Science (UK) 2 <sup>nd</sup> Year – Dip. Applied Social Studies	4 years 1 month
#13	Team Co-ordinator	39	Full-time Permanent	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	4 years
#14	Team Co-ordinator	39	Full-time Permanent	No Qualification	3 years 11 months
#15	Team Co-ordinator	39	Full-time Permanent	BA English & Sociology (Canada)	3 years 6 months
#16	Team Co-ordinator	39	Full-time Permanent	BA in Health & Social Care (OU)	3 years 4 months
#17	Team Co-ordinator	39	Full-time Permanent	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	2 years 11 months
#18	Team Co-ordinator	39	Full-time Permanent	No Qualification	2 years 6 months
#19	Team Co-ordinator	39	Full-time Permanent	BA in Applied Social Care	2 years 5 months
#20	Team Co-ordinator	39	Full-time Temporary	Diploma in Youth & Social Studies Degree in Pedagogy (Denmark)	2 years 2 months
#21	Team Co-ordinator	39	Full-time Permanent	BA in Social Care	1 year 4 months
#22	Team Co-ordinator	39	Full-time Permanent	BA Psychology	8 months
#23	Child Care Worker	39	Full-time Permanent	Diploma in Health Services Management	4 years
#24	Child Care Worker	39	Full-time Permanent	Diploma in Access Studies (UK)	3 years 11 months
#25	Child Care Worker	39	Full-time Permanent	No Qualification	3 years 11 months
#26	Child Care Worker	39	Full-time Permanent	No Qualification	3 years 1 month
#27	Child Care Worker	39	Full-time Permanent	No Qualification 3 <sup>rd</sup> Year – Dip. Applied Social Studies	2 years 6 months
#28	Child Care Worker	39	Full-time Permanent	Diploma in Learning & Education (UK)	2 years 4 months

	<i>Staff</i>	<i>Hours</i>	<i>Employment Status</i>	<i>Qualification</i>	<i>Length of Service in SCU</i>
#29	Child Care Worker	39	Full-time Permanent	BA Psychology (USA)	2 years 3 months
#30	Child Care Worker	39	Full-time Permanent	No Qualification	2 years 2 months
#31	Child Care Worker	39	Full-time Permanent	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	2 years
#32	Child Care Worker	39	Full-time Permanent	Diploma in Counselling	1 year 11 months
#33	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 11 months
#34	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 11 months
#35	Child Care Worker	39	Full-time Permanent	BA European Social Work Diploma in Social Studies (UK)	1 year 10 months
#36	Child Care Worker	39	Full-time Permanent	BA in Humanities (UK)	1 year 10 months
#37	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 10 months
#38	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 10 months
#39	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 10 months
#40	Child Care Worker	39	Full-time Permanent	BSc Psychology	1 year 9 months
#41	Child Care Worker	39	Full-time Permanent	MSc Forensic Psychology (UK)	1 year 8 months
#42	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 8 months
#43	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 8 months
#44	Child Care Worker	39	Full-time Permanent	Diploma in Public Administration (UK)	1 year 4 months
#45	Child Care Worker	39	Full-time Permanent	BA in Psychology	1 year 4 months
#46	Child Care Worker	39	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	1 year 2 months
#47	Child Care Worker	39	Full-time Permanent	No Qualification	1 year 2 months
#48	Child Care Worker	39	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	11 months
#49	Child Care Worker	39	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	9 months
#50	Child Care Worker	39	Full-time Permanent	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	9 months
#51	Child Care Worker	39	Full-time Permanent	No Qualification	9 months
#53	Child Care Worker	39	Full-time Permanent	BA in Psychology	8 months
#54	Child Care Worker	39	Full-time Permanent	Degree in Economics (Nigeria)	7 months
#55	Child Care Worker	39	Full-time Permanent	No Qualification	7 months
#56	Child Care Worker	39	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	6 months
#57	Child Care Worker	39	Full-time Permanent	BSc in Sports Rehabilitation (UK)	6 months
#58	Child Care Worker	39	Full-time Permanent	No Qualification	6 months

	<i>Staff</i>	<i>Hours</i>	<i>Employment Status</i>	<i>Qualification</i>	<i>Length of Service in SCU</i>
#59	Child Care Worker	39	Full-time Permanent	No Qualification	6 months
#60	Child Care Worker	39	Full-time Permanent	No Qualification	5 months
#61	Child Care Worker	39	Full-time Permanent	No Qualification	3 months
#62	Child Care Worker	39	Full-time Permanent	BA in Psychology and Criminology (NZ)	2 months
#63	Child Care Worker	39	Full-time Permanent	National Diploma in Applied Social Studies in Social Care	1 month
#64	Child Care Worker	39	Full-time Temporary	BA Psychology & Sociology (Canada)	2 years 7 months
#65	Child Care Worker	39	Full-time Temporary	No Qualification	1 year 9 months
#66	Child Care Worker	39	Full-time Temporary	BA in Psychology & Philosophy	1 year 6 months
#67	Child Care Worker	39	Full-time Temporary	National Diploma in Applied Social Studies in Social Care	4 months
#68	Child Care Worker	39	Full-time Temporary	No Qualification	3 months
#69	Child Care Worker	39	Full-time Temporary	No Qualification	3 months
#70	Child Care Worker	39	Full-time Temporary	Diploma in Youth and Community Development	2 months
#71	Child Care Worker	39	Full-time Temporary	BA in Irish & History	2 months
#72	Child Care Worker	39	Full-time Temporary	BA Early Childhood Development.	1 month
#73	Child Care Worker	24	Part-time Temporary	No Qualification 2 <sup>nd</sup> Year – Dip. Applied Social Studies	6 months
#74	Child Care Worker	24	Part-time Temporary	No Qualification	5 months
#75	Child Care Worker	36	Part-time Temporary	Diploma in Youth & Community Development	4 months
#76	Child Care Worker	19.5	Job Share Permanent	No Qualification	3 years 11 months

#### 4.2.2 Staff Checks

All staff, including ancillary and agency staff, had Garda clearances, and managers and care staff had two references. The DoHC guidelines on staff vetting, dated November 1994, are clear. It requires that all social care staff have garda clearance and three references. In order to comply fully with the vetting requirement all staff should have three references. It is important that all staff that have contact with the young people in the centre are appropriately vetted in order to safeguard the young people. Inspectors are of the view that the management and staffing arrangements in place, and the measures already taken and those intended by the managers in respect of staff vetting will enhance safety and stability in Ballydowd SCU. Inspectors were informed that all fifteen staff recruited subsequent to this inspection had both garda clearance and three references.

#### Recommendation

- 1. The board should continue to ensure that in future three rather than two references are obtained in line with Department of Health and Children requirements**

#### 4.2.4 *Staff rota*

There were three working shifts per day comprising an early shift, a late day shift, and a night shift. There were two waking staff per unit on night duty who checked the young people at regular intervals. There was sufficient time allowed for staff to hand over from one shift to another and for those coming on duty to prepare for their shift.

#### 4.2.6 *Staff support and supervision*

Ballydowd had clear written guidelines that recognised the importance of regular formal supervision. It emphasized the value of regular purposeful and professional supervision conducted in an atmosphere of support, encouragement and accountability, and provided an opportunity to review and plan work and identify skills and areas for development. It stated that formal supervision was particularly important in the context of the work because it is intense and demanding. It emphasised that in the special care context formal supervision should take place at least once a month, and only in extreme circumstances would a supervision session be cancelled and then not without arranging an alternative date within seven days of the original scheduled meeting.

The previous annual inspection report had recommended that a programme of staff supervision be fully implemented and that supervision should not fall into abeyance, irrespective of other pressures. In practice there had been some improvement since the last inspection. Inspectors found that in some cases there was regular monthly supervision that staff found both supportive and educational. The acting manager received monthly supervision from the ACEO of the SWAHB who is his line manager. In other cases, slippage had occurred and there were long gaps between formal supervision sessions, in some cases over five months. There were three reasons given for deficits in relation to supervision. Firstly, that there were several changes in management positions in the previous year. Secondly, that some of the staff with a supervisory role had been on extended sick leave; and finally, some supervisors said that they did not have enough confidence or training in the area of formal professional supervision. Given the complex and demanding nature of the work undertaken by Ballydowd there is the need for a high degree of support and accountability, and it is imperative that the policy on supervision is put into practice.

Inspectors found morale among the staff team high. Staff were positive about the support they received from both colleagues and managers. Individual managers were described as approachable and available to staff for informal support and consultation, and although there was some gaps in the regularity of formal supervision, staff reported that there was a high level of informal supervision.

Team meetings were viewed as a useful forum for the exchange of information, where issues could be discussed and staff were open to constructive criticism and suggestions. Two highly qualified and experienced external staff consultants were available to both management and the staff team as a group and on a one-to-one basis. Both the managers and the staff team said they found this consultancy of great value. One of the staff team summed it up aptly: “it keeps me centred, warm, and alive to the work”. The consultants also assisted senior managers with managerial, staffing, planning and other strategic issues.

The board employed an employee assistance officer who provided a counselling and onward referral service to employees of the board. In addition, staff could consult with the clinical director who oversaw the clinical aspects of the young person’s placement.

She was also the director of SWAHB Risk Assessment and Counselling Service (RACS). The units received a service from RACS which included psychological assessment, speech therapy, and other clinical services as required as well as support to staff.

## Recommendation

- The acting senior manager should ensure formal supervision of the staff team takes place in line with the centre's policy and a recommendation made in the previous inspection report in 2003.**

### 4.2.7 Staff training and development

The managers of the unit told inspectors that it was their intention to provide supervisors with appropriate training and ensure that formal supervision is regular. Sixty-five staff had received training in Therapeutic Crisis Intervention (TCI), the board's only approved method of crisis management and use of physical restraint. Sixty-three had received introductory training in the national guidelines on the welfare and protection of children, Children First. Fifty care staff had received induction training in a young people's secure unit in Scotland, and thirty of the total staff group had been trained in fire safety. Only two of the staff had training in first aid. Given the tendency to self-harm of some of the young people in the unit's care, inspectors believe that it is important to extend this training. The senior manager told inspectors that the Dublin Institute of Technology had run a special induction training course in child care for the staff team. Thirteen of the staff team were currently attending college studying for the degree in Social Care. Ballydowd also encouraged qualified staff to take students on placement.

#### Staff Training in the SCU – 4<sup>th</sup> October 2004

		TCI (61)	Children First (59)	Induction (46)	Fire Safety (30)	DSH (19)	Anger Management (16)	Life Skills (11)	Group Work (10)	Safe Care (8)	Family Welfare (7)	Cognitive Skills Training (6)	Sexual Aggression (6)	'Copping On' (5)	Sex Education (5)	Freedom of Information (5)	Health & Safety (5)	Solution Focussed Therapy (3)	Legislation (2)	First Aid (2)	Supervision (2)	PDP (2)	Trauma Model of Care (1)	
#1	Acting Senior Manager	√	√	√								√												
#2	Acting Assistant Senior Manager	√			√															√				
#3	Unit Manager	√	√	√				√																√
#4	Unit Manager	√	√	√	√	√				√												√		
#5	Acting Unit Manager	√	√	√										√			√							
#6	Deputy Unit Manager	√	√	√							√	√												
#7	Deputy Unit Manager	√	√	√							√	√												
#8	Acting Deputy Unit Manager	√	√	√			√										√							
#9	Acting Deputy Unit Manager	√	√	√							√	√												
#10	Team Co-ordinator	√	√	√	√															√				

		<i>TCI (61)</i>	<i>Children First (59)</i>	<i>Induction (46)</i>	<i>Fire Safety (30)</i>	<i>DSH (19)</i>	<i>Anger Management (16)</i>	<i>Life Skills (11)</i>	<i>Group Work (10)</i>	<i>Safe Care (8)</i>	<i>Family Welfare (7)</i>	<i>Cognitive Skills Training (6)</i>	<i>Sexual Aggression (6)</i>	<i>'Copping On' (5)</i>	<i>Sex Education (5)</i>	<i>Freedom of Information (5)</i>	<i>Health &amp; Safety (5)</i>	<i>Solution Focussed Therapy (3)</i>	<i>Legislation (2)</i>	<i>First Aid (2)</i>	<i>Supervision (2)</i>	<i>PDP (2)</i>	<i>Trauma Model of Care (1)</i>
#11	Team Co-ordinator	✓	✓	✓			✓	✓						✓									
#12	Team Co-ordinator	✓	✓	✓			✓	✓						✓									
#13	Team Co-ordinator	✓	✓	✓	✓			✓															
#14	Team Co-ordinator	✓	✓	✓			✓				✓						✓						
#15	Team Co-ordinator	✓	✓	✓								✓											
#16	Team Co-ordinator	✓	✓	✓										✓	✓								
#17	Team Co-ordinator	✓	✓	✓	✓	✓			✓				✓										
#18	Team Co-ordinator	✓	✓	✓	✓																		
#19	Team Co-ordinator	✓	✓	✓	✓		✓								✓								
#20	Team Co-ordinator	✓	✓	✓	✓	✓																	
#21	Team Co-ordinator	✓	✓	✓								✓											
#22	Team Co-ordinator	✓	✓		✓	✓	✓		✓														
#23	Child Care Worker	✓										✓										✓	
#24	Child Care Worker	✓	✓	✓	✓																✓		
#25	Child Care Worker	✓	✓	✓			✓	✓		✓													
#26	Child Care Worker	✓	✓	✓			✓	✓	✓														
#27	Child Care Worker	✓	✓	✓	✓	✓																	
#28	Child Care Worker	✓	✓	✓	✓	✓	✓		✓														
#29	Child Care Worker	✓	✓	✓			✓					✓			✓								
#30	Child Care Worker	✓	✓	✓																			
#31	Child Care Worker	✓	✓	✓	✓	✓																	
#32	Child Care Worker	✓	✓	✓	✓	✓	✓		✓														
#33	Child Care Worker	✓	✓	✓								✓											
#34	Child Care Worker	✓	✓	✓															✓				
#35	Child Care Worker	✓	✓	✓				✓	✓													✓	
#36	Child Care Worker	✓	✓	✓			✓	✓		✓													
#37	Child Care Worker	✓	✓	✓					✓	✓						✓							

		<i>TCI (61)</i>	<i>Children First (59)</i>	<i>Induction (46)</i>	<i>Fire Safety (30)</i>	<i>DSH (19)</i>	<i>Anger Management (16)</i>	<i>Life Skills (11)</i>	<i>Group Work (10)</i>	<i>Safe Care (8)</i>	<i>Family Welfare (7)</i>	<i>Cognitive Skills Training (6)</i>	<i>Sexual Aggression (6)</i>	<i>'Copping On' (5)</i>	<i>Sex Education (5)</i>	<i>Freedom of Information (5)</i>	<i>Health &amp; Safety (5)</i>	<i>Solution Focussed Therapy (3)</i>	<i>Legislation (2)</i>	<i>First Aid (2)</i>	<i>Supervision (2)</i>	<i>PDP (2)</i>	<i>Trauma Model of Care (1)</i>
#38	Child Care Worker	✓	✓	✓																			
#39	Child Care Worker	✓	✓	✓					✓	✓						✓							
#40	Child Care Worker	✓	✓	✓	✓										✓								
#41	Child Care Worker	✓	✓	✓					✓	✓	✓												
#42	Child Care Worker	✓	✓	✓	✓										✓								
#43	Child Care Worker	✓	✓	✓	✓		✓														✓		
#44	Child Care Worker	✓	✓	✓	✓	✓																	
#45	Child Care Worker	✓	✓	✓							✓		✓										
#46	Child Care Worker	✓	✓	✓	✓	✓																	
#47	Child Care Worker	✓	✓		✓																		
#48	Child Care Worker	✓	✓		✓	✓																	
#49	Child Care Worker	✓	✓		✓																		
#50	Child Care Worker	✓					✓	✓		✓													
#51	Child Care Worker	✓	✓		✓	✓																	
#52	Child Care Worker	✓	✓				✓	✓		✓													
#53	Child Care Worker	✓			✓																		
#54	Child Care Worker	✓	✓																				
#55	Child Care Worker	✓	✓			✓										✓			✓				
#56	Child Care Worker	✓			✓											✓							
#57	Child Care Worker	✓	✓		✓	✓																	
#58	Child Care Worker	✓			✓																		
#59	Child Care Worker	✓																					
#60	Child Care Worker	✓	✓																				
#61	Child Care Worker	✓																					
#62	Child Care Worker	✓	✓	✓	✓	✓																	
#63	Child Care Worker	✓	✓	✓			✓										✓						
#64	Child Care Worker	✓	✓	✓				✓	✓					✓									

		<i>TCI (61)</i>	<i>Children First (59)</i>	<i>Induction (46)</i>	<i>Fire Safety (30)</i>	<i>DSH (19)</i>	<i>Anger Management (16)</i>	<i>Life Skills (11)</i>	<i>Group Work (10)</i>	<i>Safe Care (8)</i>	<i>Family Welfare (7)</i>	<i>Cognitive Skills Training (6)</i>	<i>Sexual Aggression (6)</i>	<i>'Copping On' (5)</i>	<i>Sex Education (5)</i>	<i>Freedom of Information (5)</i>	<i>Health &amp; Safety (5)</i>	<i>Solution Focussed Therapy (3)</i>	<i>Legislation (2)</i>	<i>First Aid (2)</i>	<i>Supervision (2)</i>	<i>PDP (2)</i>	<i>Trauma Model of Care (1)</i>
#65	Child Care Worker	√	√																				
#66	Child Care Worker	√			√	√																	
#67	Child Care Worker	√																					
#68	Child Care Worker	√																					
#69	Child Care Worker	√																					
#70	Child Care Worker	√	√																				
#71	Child Care Worker	√													√								
#72	Child Care Worker	√			√	√																	
#73	Child Care Worker	√	√																				
#74	Child Care Worker	√																					
#75	Child Care Worker	√																					
#76	Child Care Worker	√																					

## Recommendations

- The board should ensure that training in formal supervision is provided to all staff employed in a supervisory capacity.
- The board should increase the number of staff trained in first aid.

### 4.2.8 Unit Management

**The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.**

At the time of the inspection Ballydowd was going through a period of managerial transition. The senior manager and manager of care had left the service. The current senior manager was in an acting position and there was an acting assistant senior manager of care. The manager of operations' position had not been filled. In unit 1 there was an acting unit manager and acting deputy unit managers. In unit 2 there was a manager and acting deputy manager and unit 3 had a permanent manager and a permanent deputy manager. They provided the day-to-day management of the units.

Thirteen shift co-ordinators oversaw the work of each shift. The unit managers met on a weekly basis with the two senior managers to discuss issues in relation to individual young people and review staffing needs and management issues. Unit managers were positive about the informal support they received from senior managers.

The managers and staff met as a group with one of the staff consultants on a fortnightly basis. The lack of certainty in relation to the permanency of managerial staff was causing some anxiety amongst the staff team. Some staff told inspectors that the departures of management in the past caused a lot of instability at the time. Notwithstanding this there was a confidence amongst the staff team in the current senior management and the managers of the units. The staff team told inspectors that that they were supported and encouraged in their work, and although there were some gaps in the regularity of formal supervision there was a high level of informal supervision.

Establishing permanent management in Ballydowd is critical to its ongoing stability and future development. At the time of inspection inspectors were informed that this was accepted by the board and plans were in place to establish a permanent management team.

### **Recommendation**

- 5. The board should ensure that management posts are filled on a permanent basis as soon as possible.**

#### *4.2.9 Monitoring*

The SWAHB had appointed a monitoring officer external to the board. In the year prior to inspection regular and frequent monitoring visits, both announced and unannounced, had taken place, and the board and acting centre manager had received a written report of the findings from the monitoring officer. There was a planned schedule of visits. After each visit he issued recommendations and on subsequent visits checked that they were implemented. While most of his recommendations in the past year had been implemented, he had ongoing concerns about the level of physical restraints and the need for an external manager to constantly review them (See section 4.4.4.2. below.) He was also concerned about the lack of discharge plans in some cases.

In addition, regulation of the heating system and expeditious repair of damage to property was an ongoing problem.

The monitoring officer had in the past year encountered some difficulty discharging his reporting responsibilities to the SWAHB. At the time of inspection he had written to the board on four occasions without receiving a reply to date. Inspectors learnt that the board had decided that the monitoring officer would in future report directly to the ACEO (Children and Families Services) of the SWAHB.

### **Recommendation**

- 6. The board should put in place arrangements to facilitate regular meetings between the monitoring officer for Ballydowd SCU and the ACEO.**

### 4.3 *Planning for young people*

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

#### 4.3.1 *Referral and placement of young people*

##### *Admissions*

During the period between the inspection in March 2003 and this inspection there had been 38 admissions to the unit. These were of 23 girls and 15 boys with an average age of 14 yrs 4 months ranging from 12 to 17. In the year from September 2003 there had been six re-admissions. This contrasts with only one re-admission during the previous three years. This has to be weighed against the longer placements during that time. Out of 38 admissions, 27 were from the three health boards in the Eastern Regional Health Authority area. The admissions outside this area were from NEHB, MHB, SHB and SEHB. The average length of placement was 3 months (13.26 weeks) with a range of one to seven months.

Each application was considered by an admissions and discharges committee. The committee comprised a board representative from five health boards including the SWAHB. It was chaired by the director of services for children and families in SWAHB. Other members included a consultant psychiatrist, the acting senior manager, a unit manager from Ballydowd, and the school principal. It met monthly but also met as required to consider requests for emergency referrals. The policy document for Ballydowd outlines the function of the committee in relation to referrals and states the guidelines they have to regard in considering applications for admission. The guidelines refer to the needs of the young people presenting for placement, the needs of the young people currently in residence, and the group dynamics and population mix within each unit and the overall facility.

Social workers making an application for admission must submit: a comprehensive care plan, an aftercare plan that identifies a discharge placement, a comprehensive social history, an up to date psychiatric assessment recommending placement from a consultant psychiatrist familiar with the special care unit, a report from the general manager and the child care manager of the referring board, a completed application form, and a report from a family welfare conference if available.

Social workers told inspectors that this level of information was extremely difficult to obtain. In particular they stated they had difficulties obtaining a psychiatric report. They said that in some cases the young person had never attended a psychiatrist and refused to go, and in other instances the young people were out of control or homeless and consequently in the circumstances not able or amenable to attending a psychiatric assessment. A second difficulty raised by the majority of referring social workers was the referral process. Social workers spoke of referring very vulnerable young people and experiencing long delays in the committee's deliberations. In some cases the response was that they should try an alternative community placement even though they had made it clear at application stage that they had already exhausted that option. In other cases social workers told inspectors that further information was required of them by letter, and they said this caused further delay as they could have given this directly to the committee if they could meet with the committee with their application. Finally, the requirement for concrete discharge plans for onward placement, although commendable, caused difficulties in some cases because of the unpredictability of the young people's progress in Ballydowd. On the other hand inspectors were informed by some of the members of the admissions committee that in some cases social workers

presented insufficient information and submitted post-placement plans that subsequently fell through and this caused distrust. Also the requirement of an onward placement was in place to protect the young people's right to liberty and to prevent the young people getting "stuck" in Ballydowd. Inspectors were informed by the board subsequent to this inspection that where a young person is unwilling or unavailable to see a consultant psychiatrist, a letter from a consultant psychiatrist confirming this was accepted. In addition and following a review of Ballydowd in consultation with stakeholders, a strategic plan was produced in January 2004. In March 2004, revised admissions criteria now stated that a psychiatric report was no longer required unless there are concerns regarding the young person's mental health.

In addition to submitting the required written information, all professionals interviewed by inspectors agreed that the attendance of the referring social worker to make an oral submission to the committee would assist by being available to clarify any supplementary questions.

In any event all admission and discharge policies will have to be reviewed in the context of the proposed implementation and commencement of Parts 11 and 111 of the Children Act 2001. Inspectors learnt subsequent to the inspection that a group with a HSE mandate has been established to review this in collaboration with other stakeholders.

## **Recommendation**

- 7. The board in conjunction with all other stakeholders should review the admissions policy and procedure with a view to expediting its process.**

### *4.3.2 Care Plans*

Comprehensive statutory care plans were prepared for all of the young people prior to admission. Care plans outlined the aims and objectives of the placement, arrangements for access to the young person by parents or others with a legitimate interest in the young person, and the support to be provided to the young person. Care plans were of a high standard and showed evidence of consultation where possible with the young person, parents and relevant others. They also showed evidence that all other options had been either attempted or considered prior to Ballydowd. Copies of the care plans were provided to the units and placed in the care file, and particulars of the plans were made known to the young person, parents and relevant others.

### *4.3.3 Reviews*

Placement review meetings, arranged by the unit, took place on a monthly basis, the dates for which were agreed with referring social workers at the time of admission. Young people, parents and others with a legitimate interest in the young people were invited to attend reviews, and reports were prepared for review meetings. Statutory review meetings of care plans were arranged by the referring social workers at greater intervals. A note of the decisions made at statutory review meetings was taken by the social work department, copies of which were provided in most cases to all parties, including parents.

In order to comply with the new requirements of the Child Care (Special Care) Regulations 2004 Section 28(1), statutory review meetings should replace the monthly placement review meetings and be initiated and organised by the social worker from the referring board. Inspectors are of the view that the review structure already in place can accommodate this.

#### 4.3.4 *Contact with families*

In its policy document and demonstrated in its practice, Ballydowd SCU recognised the importance of both family contact and contact with significant others. The SCU also produced a reader-friendly booklet specifically for parents giving guidance about their service. Each accommodation unit had a visitors' room in which access between young people and their parents and other significant people could take place. Family members were encouraged, where possible, to accompany the young people on outings. Visits were recorded in the young people's care plans and regularly reviewed. A discrete record of family contact was also kept by the manager.

Nearly all parents interviewed by inspectors spoke about the warmth of the staff and their encouragement of parental visits. There had been some difficulties between the SCU and one of the parents which led to a breakdown in regular visits to the unit. However, this was in the process of being reviewed. Three parents told inspectors that they were grateful that their children were safe. One parent told inspectors that she was warmly welcomed and kept very well informed about her son's progress. Parents were facilitated to attend review meetings and to visit the young people. Another parent phoned the inspectors to express her unreserved praise for the care and commitment shown by the staff to her son. The majority of parents were facilitated by the board to get a taxi if needed for visits. One parent experienced difficulties getting financial assistance for transport, but at time of inspection this was under review. Another parent said that at one stage her child was put on short term medication without consultation with her. Inspectors advise consultation on medical issues where reasonably practicable.

Professionals and significant others interviewed by inspectors confirmed that families were appropriately facilitated with their visits to their children. This was also confirmed by the young people themselves who looked forward to family visits. Two of the young people told inspectors that their parents were really made feel welcome when they came to visit. In summary, contact was facilitated with parents, and significant others as appropriate by telephone, in writing, through access visits both internally and externally and through attendance at case reviews and placement meetings. Overall, the parents were positive about the unit and the care their children received. Inspectors commend the staff team for their partnership approach to parental involvement in the young people's lives.

#### 4.3.5 *Legal and court work*

Each of the young people had a social worker who, amongst other things, ensured the co-ordination of all legal aspects of the young persons care such as court dates, court attendance, and obtaining court orders. All the young people had independent legal representation and there was frequent contact between them. The young people spoke highly of their respective solicitors. Ten of the twelve young people had guardians-ad-litem. Inspectors interviewed five of them who, in total, represented eight of the young people. The guardians had a high level of contact with the young people involved. They attended review meetings, were part of the care planning process, had access to unit records, and played an important role in ensuring that the rights and wishes of the young people were respected and articulated in court.

They said they felt welcomed when they visited. Two guardians commented that they had seen a lot of progress in relation to communication between the staff team and themselves. They said they met with key staff before they met with their client to inform themselves about any issues and met again after the visit to ensure open communication. Another guardian commented that he had observed a high degree of skill shown by some of the staff team in dealing with difficult behaviour, for example, by patient negotiation with the young people.

Some guardians expressed concerns. Firstly, although inter-professional communication had improved, they thought that there was room for further progress. Some of the guardians told inspectors that they were not receiving copies of TCI reports. Two of them stated that they were not informed automatically when a young person absconds or returns from an unauthorised absence. Other guardians felt that some staff could be more pro-active in giving them information about the young people that they represent. One recently appointed guardian had not realised that he was entitled to read the care file at the centre. Inspectors advise that under the Child Care (Special Care) Regulations 2004 Part 1V section V, there is now an obligation that the manager puts in place appropriate procedures to ensure that a child placed in the unit and his or her parents or guardian or guardian ad litem or any other person with a bona fide interest in the child are made aware of any rights to information they may have in accordance with the provisions of the Freedom of Information Act 1997.

The young people themselves were well informed about their court hearings, and had a good relationship with their solicitors and guardians-ad-litem. In the main, the guardians-ad-litem were positive about the service provided for the young people in Ballydowd and the manner in which they were facilitated.

#### *4.3.6 Supervision and visiting of young people*

Inspectors interviewed all social workers with statutory responsibility for young people in the unit. Social workers visited the young people within the time frame required by the regulations and visits exceeded the frequency required. They saw the young people privately. All visits were recorded in the case file with an account of any action taken. All the case files were shown to inspectors. They were universally of a high standard and contained all the relevant information and documentation as required by the Child Care (Special Care) Regulations 2004, section 25. Some of the social workers had not read the care records of the young people from time to time in accordance with the regulations. The young people told inspectors that they trusted their respective social workers and looked forward to their visits. All of the young people interviewed by inspectors knew the reason they were in a Special Care Unit. They were told either by their social worker or jointly with a member of the staff team. Although at times there were some communication difficulties in relation to receiving written reports, by and large both social workers and child care staff reported good interagency cooperation and mutual respect.

### **Recommendation**

- 8. Principal social workers should ensure that social workers read the centre records from time to time.**

#### *4.3.7 Preparation for moving on*

### ***Discharges***

During the period between the inspection in March 2003 and this inspection in October 2004 there had been 34 discharges from the unit. Eight of these were of young people who had been in the unit before the 2003 inspection. The breakdown of discharge placements is as follows: 11 went to high support units, eight to health board children's residential centres, seven to non-statutory residential provision, five home to parents, two to detention facilities as a result of criminal proceedings, and one to a foster placement with a relative.

Discharge from the unit took place as part of the care planning process and following discharge of detention orders by the court. The staff teams in the units were very aware of the fact that the young people were in the unit for a relatively short time and they began preparation work in relation to onward placement in conjunction with the social worker shortly after the placement of the young person. (See section 4.3.1 above.)

#### 4.3.8 *Emotional and specialist support*

Progress has been made in accessing specialist services since the last inspection and the board is commended for this. In the view of the inspectors in addition to the services in place young people and staff would benefit from further on site access to social workers and psychologists who could provide ongoing counselling, group work and advice. The young people admitted to Ballydowd SCU have been assessed to have emotional and behavioural reasons that require them to be deprived of their liberty to ensure that their needs are met. It is important that services for all children in care strive to provide the specialist services and emotional services necessary. However, this requirement of a service is of the utmost priority where children are detained for welfare reasons.

Ballydowd SCU had a written policy on key working and the role of keyworkers as part of the care team. The main aspects of the role were described to inspectors as developing a relationship with the young person, working with families, liaising with other professionals, and doing individual work with the young person. Time for the individual sessions was afforded by the staff rota and often key workers took young people out of the unit from time to time. The placement plans were useful tools in setting an agenda for the direct work with the key worker. The young people told inspectors that they trusted their individual key workers and would confide in them. One young person said that her key worker really cared for her and went out of her way when she needed advice and help. Inspectors observed staff interacting with the young people in a warm, attentive, humorous and caring manner.

Ballydowd had recourse to medical, dental, psychological, psychiatric and speech therapy as required. A common concern expressed by social workers and guardians-ad-litem was that there were not enough specialist staff to provide appropriate therapeutic intervention for the young people. The acting centre manager and the clinical director told inspectors that all the young people in Ballydowd have access to a psychiatrist as required, and as part of the ongoing development of the service a senior social worker and a psychologist were soon to be recruited. Inspectors urged the board to expedite this. Since the inspection inspectors have been informed by the acting senior manager that a psychologist is due to take up the post in March 2005, and the Board has advertised for a senior social work practitioner and speech and language therapist.

Inspectors were informed that a social worker had requested that one of the young people continue to see a counsellor that they had been attending for therapy prior to their placement in Ballydowd. Inspectors were informed that this was not facilitated because the young person was deemed to be at risk of absconding when visiting a professional in the community. On another occasion a young person who was attending a child guidance clinic ceased contact on admission to the unit. Inspectors were told that this was a decision taken by the clinic as the child was no longer living at home and in their catchment area.

Special care units constantly face the challenge of finding a balance between the requirement to detain a young person and at the same time meeting their needs. These challenges are generally best resolved in consultation with the young person's social worker where both parties share the responsibility to assess the risk and manage it in the best interests of the young person. Given the

vulnerability of these young people, inspectors advise that all professionals involved try to ensure that contact with significant professionals is continued especially if the young people are to be discharged back to their care.

### **Recommendations**

- 9. The board should ensure that a social work senior practitioner, a psychologist and speech and language therapist are in post as soon as possible.**
- 10. The acting senior manager, in conjunction with the social worker, should review young people's access to therapeutic services outside the centre to ensure that the need for detention does not militate against the young people receiving appropriate services.**

#### *4.3.9 Young people's care files*

The unit had a clear written policy on record keeping and file management. It emphasised the importance of clear factual recording of significant information which allows for ease of access for staff and the young people. There had been significant improvement since the last inspection. Inspectors found that the volume of information was considerable. All files had copies of care plans. In addition all files had social history reports, medical reports, and copies of legal orders and birth certificates. Inspectors advise that educational assessments are included on the file in line with the requirements of the special care regulations. The file should reflect a comprehensive view of the child's needs, abilities, and educational progress.

There was no distinction on files between documentation relating to placement reviews and statutory review meetings and in five cases inspectors could not locate minutes of review meetings. However, inspectors were informed that the system of recording and filing was under review.

### ***Register***

The unit had a register of young people placed there. It contained several of the items of information now required by Section 24(1) of the Child Care (Special Care) Regulations 2004. Two additional items are needed to fulfil the requirements of this regulation, that is, the date of the order authorising the detention of the young person and the names and addresses of legal representatives, guardians-ad-litem or any other person who has a bona fide interest in the child. The senior managers were aware of these new requirements and undertook to fulfil them as soon as possible.

### **Recommendations**

- 11. The acting senior manager should ensure that the information now required by regulation is recorded on the unit register.**
- 12. The acting senior manager should conduct a systemic review of record keeping to ensure information is more accessible.**

## 4.4 *Care of young people*

### 4.4.1 *Relationships between staff and young people*

**Young people are cared for by staff who can relate effectively to them.**

Ballydowd had a clear policy that emphasised the importance of building good relationships with the young people and affirming them in their daily achievements. There was a culture of actively seeking out the young persons particular talents and then actively ensuring that they get the opportunity to develop in areas such as music and art.

All the young people could identify a staff member they could confide in if they were upset. Three of the young people said that the staff team go out of their way to help in any way they can. There was a high degree of consultation in relation to food, leisure activities and education. The staff team were aware of the young peoples rights and their magnified importance in the context of a detention order, and great efforts were made to ensure that the young people visited family or significant others outside the unit where possible. Staff were also aware of the potentially oppressive nature of supervision in a Special Care Unit and attempted to give the young people space. Inspectors had concerns about single separation as referred to in section 4.4.4.2.

### 4.4.2 *Quality of care*

**Day-to-day care is of good quality and provided in a way that takes account of the individual needs of young people in relation to age, race, culture, religion, gender and disability.**

Young people made and received telephone calls, and wrote and received letters privately, subject to safety considerations and any relevant conditions of the Court Order. They choose their own clothes and daily menu. Inspectors had some concerns about a voucher system of payment that limited the choice of shops available to the young people and in accordance with the principle of normalisation, and allowing for safety considerations, advise a review of this practice. Most professionals interviewed stated that the young people received a high quality of care. Great efforts were made to create a more natural environment inside and around the unit. A beautiful mural of welcome had been painted on one of the unit's walls by some of the staff team and young people who assisted a member of the staff team who was also an artist. He was also creating a garden outside with the help of the young people, and they were proud of their work. He and other members of the staff team were full of ideas for further creative work with the young people but told inspectors that they would need a small work shop to develop this aspect of their work. Inspectors commend this creative approach to working with the young people.

Ballydowd SCU had a policy that promoted respect for the cultural, religious, ethnic, sexual orientation and the family background of each resident. These were seen as crucial factors in the creation of an integrated identity for the young person. A Roman Catholic chaplain offered a religious service on site on alternative Sundays and on religious festive days such as Christmas and Easter. Young people of other faiths were facilitated in the practice of their religion. All the young people interviewed were aware of this policy and confirmed it in practice. Finally, staff displayed sensitivity towards, and a clear understanding of, the requirements of confidentiality in their work with the young people.

#### 4.4.3 *Rights of young people*

**Young people are cared for in a manner that safeguards and actively promotes their legal and civil rights.**

##### 4.4.3.1 *Access to information*

Ballydowd did not have a written policy on access to information. The only reference to this area in the general policy document was in the section on child protection that stated, on or prior to arrival, the young people will be given a Children's Booklet that outlines their rights. The Children's Booklet informed the young people that they had a right to access any files, reports or records written about themselves. Some of young people said they had not received a copy and told inspectors that they would have to seek permission to see their files from their respective social workers, while others said that they could read them but were not interested. Some staff interviewed were not aware of the policy in relation to young people accessing their files, but if a request was made, would refer to senior management or the young person's social worker. Given the limits placed on the young peoples liberty, the complex and challenging nature of the work, and the importance of being conscious at all times of the rights of the young people, inspectors advise that a member of the staff take on the role of a children's rights officer to bring all aspects of children's rights to the attention of the staff team on an ongoing and constant basis.

A policy should be devised on young people's right to information that outlines how the young people can be guided in exercising this right.

#### **Recommendations**

- 13. The acting senior manager should ensure that a member of staff undertakes the responsibilities of a children's rights officer.**
- 14. The acting senior manager should develop a written policy on access to information that outlines how the young people can be guided in exercising that right.**

##### 4.4.3.2 *Consultation*

In relation to every day issues, young people were consulted about activities, the kind of trips outside of the unit that they would like, walking and shopping. They chose their own clothes and daily menu.

The young people were consulted about their placement and reviews and invited to attend them. Some of the young people said that their preferences in relation to onward placements were not always considered. There was a high degree of consultation evident in the content of their school courses. The staff team were very attentive to the young people's leisure interests and talents and encouraged them in activities such as music, art and drama. They had invited national figures in these areas to come and visit and encourage the young people.

#### 4.4.3.3 *Complaints*

The policy document outlined a procedure to be followed in the event of a young person wishing to make a complaint. The procedure was outlined in the young people's booklet. However, some of the young people interviewed could recall receiving it. Inspectors found that this booklet lacked clarity and moved from minor complaints to serious allegations without any graduated levels in between. The contents should be revised to reflect a continuum from low key complaints to serious allegations. However most of the young people interviewed were aware of the complaints procedure and their right to make a complaint. They also had access to pre-addressed 'help cards' that they could write in confidence, and the acting manager of care checked every day to see if there were any cards in the unit's internal post box.

There was a recently proposed independent element in the complaints procedure. Inspectors were told that from now on, in addition to the social worker, all complaints would go to a project worker from RACS who will act as an external complaints officer. It was proposed that she would be available on an on call basis and meet with the young people monthly to encourage them to voice any concerns they may have about their care. Inspectors were informed by the Board that this worker would have no other role in the unit whatsoever. Inspectors advise that in complaints procedures perception is of crucial importance and given the fact that the project worker is line managed by the clinical director who is part of the management team this role could not be construed as completely independent of the unit. Inspectors advise further consideration of this with a view to appointing a professional manifestly independent of the unit.

A review of records showed that the young people's complaints were generally addressed. However, inspectors were concerned to find that records of a restraint that was subject of a complaint by a young person were not located despite repeated requests by inspectors as the file had been returned to the board for archiving. (See section 4.4.4.2.) Inspectors also had some concerns about delays in notifying some social workers of complaints, and they recommend the need for more clarity amongst staff about allegations against staff or child protection concerns being notified immediately to social workers as per Children's First, rather than investigated internally and subsequently notified to social workers. (See section 4.4.5.)

### **Recommendation**

- 15. The board should ensure that the proposed independent element in the complaints procedure commences as soon as possible.**

#### 4.4.4 *Discipline*

**Young people whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the health board.**

##### 4.4.4.1 *Promoting good order*

Ballydowd SCU had a policy that recognised the value of positive behaviour management which encouraged a framework of clear, concise and consistently applied boundaries in the young people's lives. Within this framework young people were encouraged to develop their personal identity and a sense of empowerment and responsibility for their own actions. In practice, methods used for managing behaviour were clear, well-recorded and signed-off by the management. Young people and the staff team had a thorough understanding of them. There were

written guidelines on permitted and prohibited sanctions. All sanctions were recorded in writing stating the reason for the sanction, its duration and termination.

Records of sanctions also included positive rewards given to young people, particularly in relation to effort made or where they demonstrated self control in challenging circumstances. Inspectors found that in some cases the section which specifies what benefits accrue to the young person were not filled out and advise completion to fulfil this positive and progressive practice.

#### 4.4.4.2 *Restraint and single separation*

Ballydowd had a written policy that it was a requirement that all staff had to be trained in therapeutic crisis intervention (TCI). There are several dimensions to this approach such as, anticipating and defusing highly charged situations, physical restraint, and helping young people make sense of their behaviour through reflection. Nearly all the staff received training in the use of physical restraint and a staff member who had not received training could not be involved in physically restraining a young person. During the inspection, inspectors witnessed a highly skilled, sensitive, and effective application of TCI. One of the young people had become upset and out of control one afternoon and was a danger to themselves and others after coming into possession of a knife. The unit leader and her team displayed good team work and highly refined judgement in knowing how to deal with the situation and by patience, gentleness, firmness and skilled negotiation, managed to diffuse the situation without compromising the safety of the young person or the staff team.

<i>Young person</i>	<i>Between:</i>	<i>And:</i>	<i>Physical Restraints</i>	<i>Single separations</i>
#1	14.03.04	25.07.04	8	10
#2	18.07.04	28.09.04	2	0
#3	27.06.04	20.09.04	5	9
#4	24.04.04	20.09.04	35	0
#5	05.08.04	20.09.04	8	12
#6	09.05.04	15.07.04	5	21
#7	01.08.04	20.09.04	11	0
#8	30.04.04	19.09.04	6	0
#9	14.07.04	20.09.04	9	4
#10	01.07.04	20.09.04	11	4
#11	27.06.04	20.09.04	3	11
#12	03.08.04	20.09.04	0	0

As shown in the table above, inspectors were furnished with details of the use of physical restraint in relation to the young people in the SCU at the time of inspection. It recorded the number of physical restraints of the twelve young people, the date of the incident and time of the restraint and the staff members involved. There were 103 physical restraints in total. One young person was never restrained. Another young person was restrained between 24<sup>th</sup> April and 19<sup>th</sup> September 2004 a total of thirty-five times. They averaged five a month in this case.

Some of the young people told inspectors that physical restraint was sometimes used if they refused to take directions such as being asked to go to their room or come back to the accommodation block after playing outside. Other young people told inspectors that they had been hurt during a restraint. While inspectors acknowledge that some of the young people can display extreme behaviour that endangers both other young people and the staff team, the young people must be constantly told and shown that it is never used as a method for compliance with staff

directions. Inspectors were assured by the acting senior manager that physical restraint was never resorted to in this way. At times inspectors found some of the recording of physical restraint too general to access and therefore of limited value in forming a judgement on its appropriateness in particular incidents.

Inspectors were concerned to find that records of a restraint that was subject to a complaint by a young person in July 2003 were unable to be located despite repeated requests by inspectors. The acting senior manager told inspectors they had been archived in the health board headquarters in Naas. This is unacceptable. Inspections take place annually and as part of the inspection process all complaints made after the last inspection are requested. It is reasonable to expect that the centre would anticipate this and store relevant material for ease of access.

Staff interviewed by inspectors showed an awareness of the traumatising effect of an over reliance on the use of physical restraint and single separation and stated that they vigorously questioned and analysed its use on each occasion. Inspectors found that Ballydowd's methods of managing behaviour, while prima facie reasonable, nonetheless were in need of continual rigorous review and monitoring.

While the policy and practice of restraint was being monitored by the acting senior manager and the external monitoring officer, inspectors advised the manager and monitor to frequently review restraints to ensure strict compliance with best practice at all times. It was not clear at times if an assault by a young person happened during a physical restraint or preceded it. The forms did not reflect the full impact of what happened and in some cases they were not countersigned by managers. On numerous occasions a physical restraint would be followed by a single separation. The acting senior manager told inspectors that this was recorded in the TCI form and not as a single separation per se. This is unacceptable. Single separation must be separately recorded in accordance with the special care regulations.

The acting senior manager had a record of all restraints notified to the relevant health board and other bona fide parties. Some social workers and guardians-ad-litem told inspectors that sometimes they did not get notification of a physical restraint.

The written procedures in respect of single separation were shown to inspectors. Inspectors also received census data on single separation from the SCU manager. They were in line with the Department of Health and Children guidelines on the use of single separation in special care units except in the monitoring of a time limit. The DoHC guidelines on single separation state that after 30 minutes the special care unit manager or manager on call should be contacted to determine the next steps. It also outlined who was to be notified. There was a total of 71 single separations in the year prior to inspection. Seven of the 12 young people had experienced single separation. The policy needs to be changed with clear guidelines outlining how long a single separation can continue and what is required for it to end.

Inspectors came across a situation where at times there were only two young people in the unit. One of the young people was on single separation for significantly long periods of time. Consequently this meant that the other young person was also inadvertently on single separation as well because there was no other young person in the unit, and they were unhappy with this. The young people told inspectors that on single separation they missed the company of other young people. Although inspectors noted that there were ongoing attempts to end this aspect of practice, it needs to be further reviewed. Between 5<sup>th</sup> July and 24<sup>th</sup> August 2004 one young person was in single separation a total of 24 times. There is the ever-present possibility that the use of single separation could develop into an approach to managing difficult behaviour. The manager kept a

record of single separation and notification to the health board and other parties with a bona fide interest in the young person. Some social workers and guardians-ad-litem told inspectors that sometimes they were not notified.

### **Recommendations**

- 16. Staff should receive further training on comprehensive recording of physical restraint.**
- 17. The acting senior manager should ensure that the unit policy on the use of single separation is modified to include a thirty minute management review in order to comply with the DoHC National Guidelines.**
- 18. The acting senior manager should ensure that the guardians-ad-litem and the social workers are notified of a single separation at all times.**
- 19. The acting senior manager should ensure that when a complaint is made about physical restraint all relevant material is accessible for inspection.**

#### *4.4.4.3 Unauthorised absences*

As part of their placement plan, young people may, from time to time, leave the SCU accompanied or unaccompanied by care staff. Decisions in relation to young people leaving the unit were made by staff in consultation with referring social workers.

The unit had a written procedure for dealing with unauthorised absences. It stated that each absence was notified to the unit manager, social worker, Gardai, parents, health board solicitor and the guardian-ad-litem where there was one appointed to the case. It was practice for staff in the unit to keep parents informed while young people remained absent, and on the return of the young person, the procedure was to inform all those who had been notified of the absence. Two of the guardians-ad-litem informed inspectors that at times they were not notified of incidents of unauthorised absences. In the year prior to inspection there had been a total of fifty absconsions. Six of the young people had absconded and the average frequency was five times, for two days at a time. In four of the cases, unauthorised absences involved not returning to the unit following family access visits. Upon their return they were made feel welcome and the reason for absconding explored with the young person in most cases.

Inspectors were given different accounts of the unit's procedure when young people return, or want to return on a voluntary basis from unauthorised absences. Four professionals external to the unit told inspectors that in some cases it is unit policy to request that a young person go to a garda station, so that they can be accompanied by the garda on their return to the unit. When questioned about this the unit manager said that if they came to the gate they would be let in but if they rang in they would be told to go to the nearest garda station. There was no written policy describing this practice. Unless there is a compelling reason or the safety of the young person is at issue inspectors advise a review of this procedure reflecting on its potential to further stigmatise the young people. There was a discrete record of all unauthorised absences in the care file.

## Recommendations

- 20. The acting senior manager should ensure that the procedure in relation to voluntary return from unauthorised absence is reviewed.**
- 21. The acting senior manager should ensure that guardians-ad-litem receive notification of all unauthorised absences.**

### 4.4.5 *Safeguarding and child protection*

The centre has a written policy on the safety of children which covered some aspects of safeguarding practice. It regarded the active promotion and explanation of child protection processes to all residents as an essential part of the policy. It stated that young people in the care of Ballydowd are actively helped to understand the content of the child protection policy and if necessary how to use the policy. It sought to develop a culture that encouraged staff to listen to the young people and develop open communication and transparent practice between all staff working in the SCU. Additionally, it emphasised that safeguarding and child protection was constantly reinforced through training and supervision. The centre manager and the manager of care were the designated internal child protection officers to whom safety concerns would be notified in the first instance. The policy in relation to child protection was detailed and comprehensive and gave clear guidance that the relevant social worker was to be notified of any child protection issues.

In practice, inspectors found that the staff were aware of several safeguarding practices. They told inspectors that if they had a concern about a colleagues' practice they would either bring it up with the person, or raise it with their supervisor. If it was more serious they would raise it with the centre manager. The staff members interviewed by inspectors said that there was a culture in Ballydowd that encouraged staff to make management aware of any personal issues that might affect their work with the young people. Staff also knock before entering a young person's room unless they are concerned with the young person's immediate safety.

However, inspectors had concerns about delays in notifying social workers of complaints that had a child protection element. There seemed to be a lack of clarity about allegations against staff, safeguarding issues or child protection concerns being notified immediately to social workers as per Children First, rather than investigated internally and social workers being subsequently informed. Inspectors came across incidents and complaints that fell into the realm of child protection and where immediate notification did not take place. These were complaints where there was, or could reasonably be construed, as having potential grounds for child protection concerns. In one case inspectors were informed in writing by a social worker that he was not informed of an incident until he learnt of it during this inspection. In addition, the social worker added that when he subsequently received a copy of the complaint he noticed that it recorded that he was informed of its resolution some three weeks after the incident. He informed inspectors that he had not received this information on or before the date of resolution in spite of the fact that it was recorded that he did.

These are not matters for the internal discretion of a manager or member of the staff team. All concerns about child protection must go to the social worker as per Children First. Procedures needed to be clarified for all staff. Inspectors advise a review of practice in consultation with the child care manager of SWAHB. Consideration could be given to notifying her of any concerns in relation to safeguarding and child protection as a further safeguard.

## Recommendations

22. **The acting senior manager should ensure that all staff receives further training in safeguarding and child protection in line with Children First National Guidelines for the Protection and Welfare of Children.**
23. **The acting senior manager should review the system of recording notification to outside professionals to ensure that they are notified and that a record of all correspondence is maintained.**

### 4.4.6 *Health*

All medical records were held in each unit's staff office. The administration of medication to the young people was also recorded as part of the care record. In each of the three units both prescribed and non-prescribed medication was kept in a metal locked cabinet in each unit's staff office.

All the young people were given a medical examination on admission to Ballydowd SCU. At the time of inspection Ballydowd was using a medical on-call agency for general practitioner services. Inspectors did not find this arrangement satisfactory due to the continuous changes of doctors visiting the young people. One of the young people told inspectors that she would have preferred a female doctor for certain medical conditions. However, inspectors were told by the board that this was being addressed, and a local general practitioner service that could accommodate this was in the process of being contracted to provide medical care. The young people had access to all other health services including dental and ophthalmic as required, and they received medical treatment after returning from periods of unauthorised absences. Psychological and psychiatric services were provided by the SWAHB Risk Assessment and Counselling Service which is conveniently located beside Ballydowd, and the director of clinical services told inspectors that she could access psychiatric services for the young people as required. It provided a clinical team for the young people and was highly valued by the staff team. The centre operated a no smoking policy and staff did not smoke in the young people's presence at any time. All of the young people attended courses on drug awareness and sexual health appropriate to their age, needs, and level of understanding.

Two of the young people were on medication prescribed by a psychiatrist and this was regularly reviewed. The young people enjoyed a varied and healthy diet and exercised regularly.

## Recommendation

24. **The board should ensure that the general practitioner service is regularised as soon as possible.**

### 4.4.7 *Privacy dignity and individuality*

Although there was a high degree of supervision of the young people efforts had been made to create some privacy. Screens had been installed to ensure privacy for the young people when using their showers.

Young people told inspectors that their families were warmly treated and they were facilitated and encouraged as much as possible in maintaining contact with their families. Subject to court imposed restrictions they were able to make telephone calls in private. Young people made and

received telephone calls, and wrote and received letters privately, subject to safety considerations and any relevant conditions of the Court Order. They told inspectors they felt they were treated as individuals and they were constantly asked to make choices about activities, meals, school and work which made them feel involved and respected. Each individual's talent was valued by the staff team. Inspectors observed the young people playing music singing, dancing playing basket ball and football with individual members of the staff team and commend the staff for the sensitive, patient, engaging and encouraging way they related to the young people entrusted to their care.

#### 4.4.8 *Aspects of daily living*

The daily routine was described to inspectors. The young people were first called at 8.45 a.m. They had their breakfast and prepared for school. School started at 10 a.m., and the first class was from 10 a.m. to 11a.m. From 11a.m. to 11.30 a.m. they returned to the unit for their break. Following a half hour break in the unit, they attended school again until lunch. The school day ended at 3.30 p.m. From then until 8.30 p.m. the young people took part in planned activities, from doing homework to spending time with their key worker, to going for a walk, drama lessons, homework, watching television, and just chatting with staff and the other young people. Supper was at 8.30 p.m., and during the week bedtime was 9.30 p.m.

Some of the young people complained that they could not mix with young people in the other units, and there was a practice that only one unit at a time had access to at outside leisure activities. This meant that at times the young people could not mix outside of school hours. This had an isolating impact on those young people who shared a unit with one other young person who was being separated. Inspectors advise that, having regard to the principle of normalisation, this practice be reviewed and constantly risk assessed to maximise the young people's capacity to socialise constructively with each other.

#### 4.4.9 *Personal appearance*

All of the young people wore their own clothes and were encouraged by staff to develop good self-care habits. They accompanied staff for clothes shopping and had choice in relation to purchases. Some personal possessions were kept in lockers outside the young people's bedrooms. Overall, all the young people looked well.

#### 4.4.10 *Leisure activities*

There was a good range of outdoor and indoor activities available to the young people. Each young person's interest was catered for as far as was feasible. Some young people played football and worked out in the gym. Others played golf, went to the cinema, played pool or went for a walk. One young person wrote beautiful music and poetry, encouraged and ably assisted by one of the staff team and the teachers. Time spent in the outdoor play area had to be co-ordinated between units, and this was confined to one and a half hours a day at the time of inspection. Inspectors were informed that this was for security reasons. Some of the young people found this confining and told inspectors that sometimes time outside was cut to forty- five minutes if there was a problem in the unit. Inspectors would ask the management to consider ways of expanding outdoor play time. The young people also have access to the school unit outside school hours for computers, music and craft work.

## 4.5 *Premises, safety and security*

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

### 4.5.1 *Risk Assessment*

The board had not carried out a safety check of the premises on the basis of potential for self-harm. Inspectors were told by the ACEO of the board and the senior managers of the unit that they were giving this urgent attention. The school building should be included in this assessment. Day-to-day decision making about visits outside the unit were risk assessed.

### **Recommendation**

**25. The board should ensure that a safety check of the premises on the basis of potential for self-harm is carried out as soon as practicable.**

### 4.5.2 *Location and design*

Ballydowd is located in South West Dublin. It comprises an administration building, three residential blocks, a school building and a recreation block. All buildings are single storey, are arranged in a 'c' shape with an open space for recreational activities, and enclosed by a tall perimeter wire fence.

### 4.5.3 *Accommodation – general*

In general the accommodation consists of six buildings in an enclosed campus forming an arc around a large open space in which there was a hard-surfaced basketball pitch, lawns, some flower beds, and areas of raised decking. Three of the buildings were units of accommodation in which both boys and girls were detained together. At the time of the inspection all three of them were in use. They comprised single storey buildings with design specifications for detention that included locks on all doors, external and internal, and minimal furnishings secured to floors and walls in the bedrooms. Each had its own kitchen and laundry facilities.

Each young person had his or her own bedroom. The bedrooms had an en-suite shower and toilet, and individual locked cupboards accessible from the corridor outside the room in which young people could keep personal possessions. The lounges and dining areas had suitable moveable furniture affording a level of comfort and a more domestic ambience. Two of the accommodation units had been attractively decorated with murals and motifs designed by staff and young people. The premises were adequately lit, but there had been problems with the ventilation in the past, and the heating was not easy to control. These problems were known to the managers of the unit. The unit also had a contract for the cleaning of the unit which was of a good standard. Apart from the recreational facilities outside there was a gymnasium and a well-equipped fitness suite in one of the other buildings. The other two buildings housed the administration offices and the on-site school. The overall standard of the accommodation was good.

#### 4.5.5 *Maintenance and repairs*

The general standard of décor and maintenance was good. Maintenance was purchased as needed from private contractors. However, inspectors were informed that there were ongoing difficulties accessing private contractors because of other commercial demands on their time. Inspectors advise that the board seek to remedy this unsatisfactory situation.

#### 4.5.6 *Safety and fire precautions*

The unit was last subject of a health and safety assessment on 10<sup>th</sup> February 2003. The assessment made recommendations in respect of 78 hazards. At the time of this inspection 62 of these had been acted on. Of the remaining 16, four were for high risk hazards. These concerned the provision of condenser dryers for the residential units and the need for a check on the pressure in the water hydrants. There were 12 medium to high risks identified in the assessment. Half of these had been attended to at the time of this inspection. Inspectors recommended to the board that the high risk hazards be attended to immediately and that a new health and safety assessment be carried out. Inspectors found that daily practices were characterised by a high level of awareness of safety, and that potentially harmful materials were stored safely. The unit had suitable arrangements in place for the reporting and recording of accidents. Once an up-to-date health and safety assessment, including the special assessment for potential self-harm by the young people has been carried out, the requirements of this standard will be met.

The senior managers of the unit provided the inspectors with evidence that a fire alarm and detection system had been installed and tested on 26<sup>th</sup> February 2003, and with a certificate showing that all fire fighting equipment had been checked on 1<sup>st</sup> July 2004. They also provided written confirmation that staff training in fire safety had taken place on 17<sup>th</sup> November 2003 and that a demonstration to staff in the use of fire extinguishers had taken place on 21<sup>st</sup> January 2004. Fire drills had taken place in the unit as follows: on 3<sup>rd</sup> October, 10<sup>th</sup> December and 17<sup>th</sup> December 2003, and on the 6<sup>th</sup> January and 23<sup>rd</sup> September 2004. Given that the turnover of young people will become more rapid as the orders authorising their detention become shorter, inspectors are of the view that there is a case for having fire drills more frequently. At the time of the inspection, a total of forty six staff, including care and ancillary staff, had received training in fire safety. Inspectors received copies of written confirmation from a suitably qualified person that adequate precautions against fire were in place in the unit.

#### 4.5.7 *Security*

An appropriate level of security was provided by the use of closed circuit television throughout the campus. Within each accommodation unit there were discrete viewing panels in the walls to the bedrooms. Staff carried personal alarms and there was a system of response from each unit on each shift so that a risk to the personal safety of young people or staff could be managed quickly.

#### 4.5.8 *Insurance*

Inspectors were provided with written confirmation that Ballydowd is adequately insured. The policy is due for renewal on the 1<sup>st</sup> January 2005. The requirement of this regulation has been met.

#### 4.6. *Education*

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

Ballydowd SCU had a Department of Education and Science Special School on campus staffed by a principal and four teachers with access to part-time teachers as required. Ballydowd had a written policy in relation to education that stated its aim was to deliver an education of the highest quality in order to raise achievement and reduce inequality. In practice, inspectors found that education was highly valued as a vehicle for enhancing self-esteem and in securing the best future for young people. The principal told inspectors that there was a culture within the school that attended to every aspect of young person's educational needs. Central to this culture was the expectation that each young person maximise their educational opportunities while at Ballydowd.

The principal also told inspectors that there was a well qualified staff team with wide experience of special education. The school liaised with the schools that the young people attended prior to admission and after discharge from Ballydowd. The school had a policy that aspired toward integration with professionals in Ballydowd and professionals involved with the young people in the community. It further stated that the care staff who accompanied the young people to school were an integral part of the school. There was also an education support team for each young person consisting of a teacher and a member of the care staff team. Teachers had been attending handover meetings, but inspectors were informed that this had not been happening immediately prior to the inspection. One theme that emerged repeatedly during the inspection was the desire from the care staff team for more contact with the school to ensure greater integration and closer intra agency cooperation. In order to progress this, inspectors advise the creation of a rota system that would facilitate the attendance of teachers at staff meetings.

An individual education plan was prepared based on an educational assessment for each of the young people in order to maximise his or her educational potential. All educational options were explored for each young person. Young people were encouraged to take ownership of their educational experience and inspector saw evidence of extensive consultation with the young people in relation to their educational plan and chosen curriculum. It was recognised by staff that some of these young people had difficulties in the past, and there was a high level of commitment to make education positive and relevant for them. Preparation for state exams and assessments is encouraged for all pupils and the school is registered as an examination and assessment centre. All the young people attend school full-time. Eleven of young people attend Ballydowd special school and one young person attends a special school in the community. Eight were completing six Further Education and Training Awards Council (FETAC) modules at the time of inspection. The programme was structured to allow students to work and complete short term goals. The modules the young people had chosen incorporated academic knowledge, art, and social and life skills.

All of the young people interviewed by inspectors said they really liked going to school in Ballydowd. One young person said it was fantastic. Another young person said doing exams was now "no problem". Some of the young people showed inspectors some of their art work which was very impressive. Inspectors commend the school for the innovative and responsive way they have dealt with the young people's educational needs.

*Summary of recommendations*

1. The board should continue to ensure that in future three rather than two references are obtained in line with Department of Health and Children requirements.
2. The acting senior centre manager should ensure formal supervision of the staff team takes place in line with the centres policy and a recommendation made in the previous inspection report in 2003.
3. The board should ensure that training in formal supervision is provided to all staff employed in a supervisory capacity.
4. The board should increase the number of staff trained in first aid.
5. The board should ensure that management posts are filled on a permanent basis as soon as possible.
6. The board should put in place arrangements to facilitate regular meetings between the monitoring officer for Ballydowd SCU and the ACEO.
7. The board in conjunction with all other stakeholders should review the admissions policy and procedure with a view to expediting its process.
8. The principal social workers should ensure that social workers read the centre records from time to time.
9. The board should ensure that a social work senior practitioner, a psychologist and speech and language therapist are in post as soon as possible.
10. The acting manager, in conjunction with the social worker, should review young people's access to therapeutic services outside the centre to ensure that the need for detention does not militate against the young people receiving appropriate services.
11. The acting manager should ensure that the information now required by regulation is recorded on the unit register.
12. The acting centre manager should conduct a systemic review of record keeping to ensure information is more accessible.
13. The acting manager should ensure that a member of staff undertakes the responsibilities of a children's rights officer.
14. The acting centre manager should develop a written policy on access to information that outlines how the young people can be guided in exercising that right.
15. The board should ensure that the proposed independent element in the complaints procedure commences as soon as possible.
16. Staff should receive further training on comprehensive recording of physical restraint.

- 17. The acting senior manager should ensure that the unit policy on the use of single separation is modified to include a thirty minute management review in order to comply with the DoHC National Guidelines.**
- 18. The acting senior manager should ensure that the guardian's ad litem and the social workers were notified of a single separation at all times.**
- 19. The acting senior manager should ensure that when a complaint is made about physical restraint all relevant material is accessible for inspection.**
- 20. The acting senior manager should ensure that the procedure in relation to voluntary return from unauthorised absence is reviewed.**
- 21. The acting senior manager should ensure that guardians-ad-litem receive notification of all unauthorised absences.**
- 22. The acting senior manager should ensure that all staff receives further training in safeguarding and child protection in line with Children First National Guidelines for the protection and welfare of children.**
- 23. The acting senior manager should review the system of recording notification to outside professionals to ensure that they are notified and that a record of all correspondence is maintained.**
- 24. The board should ensure that the general practitioner service is regularised as soon as possible.**
- 25. The board should ensure that a safety check of the premises on the basis of potential for self-harm is carried out as soon as practicable.**