Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

INSPECTION OF A CHILDREN'S RESIDENTIAL CENTRE IN THE HSE SOUTH

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Contents

1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Health Service Executive South (HSES). Sharron Austin (lead inspector) and Michael McNamara and Orla Murphy (co-inspectors) conducted the inspection under Section 69 (2) of the Child Care Act 1991 over a three day period from the 21 – 23 June 2011. The inspection included a visit to a holiday house at a seaside resort owned by the HSE. Staff and children used this facility during the months of July and August. Sharron Austin (lead inspector) and Bronagh Gibson (co-inspector) visited this facility on the 4 July 2011.

The centre was last inspected by the SSI in March 2008 (Report ID.202). The follow-up inspection in May 2009 (Report ID.324) found that the majority of the recommendations had been met.

The centre was a large campus based centre completed in the late 1980's and was located on the outskirts of a small town. It comprised four separate residential units, each providing accommodation for up to six boys of similar age. The site also included a purpose-built and well resourced school, administration buildings for offices, conference and meeting rooms, a separate refectory, a small two bedroom bungalow suitable for semi independent living which had been used for young people prior to leaving the centre, a large laundry, a gymnasium, a swimming pool, an all-weather football pitch, accommodation facilities which were often used by visiting parents and families of the children in the centre, and extensive grounds. There was also a chapel which was used for religious services which were also attended by the members of the local community. It was the largest residential centre in the country and provided a national resource accepting referrals from every HSE local health area. At the time of inspection boys placed in the centre were from four HSE areas and the majority were in voluntary care.

The written statement of purpose and function provided to inspectors described the centre as providing medium to long term care for up to 24 young people (boys) aged between 11 and 15 years on admission.

On the first day of the inspection there were 17 boys in the centre. Four boys were discharged later on the first day following completion of their Junior Certificate examinations.

Special Arrangement
In one particular case that came before the High Court during the 12 months prior to the inspection, a part of the centre had been designated as a special arrangement. A separate unit located on the grounds of the centre was the allocated place of safety. The unit was re-assigned to facilitate the emergency admission of the young person, who was at significant risk and was placed there on a High Court detention order. This was a temporary arrangement, after which it was envisaged that the young person would return to their previous residential placement. An inspection of this arrangement took place on 19 October 2010. This arrangement had ended at the time of this inspection.

Overall, inspectors found that this was a unit that was not built to the standard of a special care unit and therefore could not meet the standard on design, but that the placement was a targeted intervention that provided a suitable temporary, safe and stable environment for the young person in question, with specific aims and objectives to the placement. Those interviewed told inspectors that despite initial concerns and problems, the emergency

admission was successful and the young person had subsequently moved to supported lodgings.

1.1 Methodology

Inspector's judgements are based on evidence verified from several sources gathered through direct observation, an inspection of accommodation and interviews with seven young people, the director, two deputy directors, two care managers, two unit managers, nine child care staff, a nurse who provided a dedicated service to the centre, the centre's psychologist, school principal and deputy principal and the local HSE general manager. Telephone interviews were conducted with 12 social workers, a social work team leader, three parents and a care manager.

Inspectors also had access to the following documents:

- The centre's statement of purpose and function
- The centre's policies and procedures
- The centre's register
- The young people's care plans and care files
- A sample of personnel files
- Census of staff
- Census of young people
- Administrative records
- Staff rosters
- Supervision records
- Training records
- Fire safety and building control compliance documents
- Evidence of insurance
- The centre's health and safety statement
- The centre's health and safety audits
- Details of physical interventions for the previous twelve months (72)
- Details of unauthorised absences for the previous twelve months (195)
- Details of child protection concerns (10)
- Questionnaires completed by young people (1)
- Questionnaires completed by social workers (10)
- Questionnaires completed by Guardian-ad-litems (1)
- Questionnaires completed by parents (2)
- The HSE monitoring officer's report (1)

1.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of all those involved in this inspection.

1.3 Management structure

The centre director reported to the general manager, who in turn reported to the area manager.

1.4 Data on Young People

On the first day of fieldwork the following boys were registered in the centre:

Listed in order of length of placement

Child	*Age*	*Legal Status*	*Length of Placement*	*Number of previous placements*	*HSE Referral Region*
# 1	15	Voluntary care	3 years 2 months	0	HSE West
# 2	15	Care Order	2 years 7 months	2 foster care 1 residential	HSE Dublin North West
# 3	15	Voluntary care	2 years 7 months	0	HSE Dublin Mid Leinster
# 4	13	Care Order	1 year 9 months	2 foster care 1 residential	HSE South
#5*	15	Voluntary care	1 year 9 months	0	HSE Dublin Mid-Leinster
#6*	15	Voluntary care	1 year 5 months	0	HSE South
#7 *	16	Care Order	1 year 3 months	1 foster care 2 residential	HSE South
#8	15	Voluntary care	13 months	1	HSE Dublin Mid-Leinster
#9	14	Voluntary care	8 months	0	HSE West
#10	16	Voluntary care	8 months	3 foster care 1 residential	HSE Dublin Mid-Leinster
#11	14	Care Order	8 months	0	HSE West
#12	16	Voluntary care	3 months	1 residential	HSE South
#13	13	Voluntary care	11 weeks	0	HSE West
#14	17	Voluntary care	11 weeks	1 residential	HSE Dublin South
#15 *	14	Voluntary care	6 weeks	1	HSE Dublin Mid-Leinster
#16	15	Care Order	3 weeks	3 high support 1 detention	HSE South
#17	14	Voluntary care	1 week	0	HSE South

** Four boys were discharged on the first day of the inspection fieldwork.*

2. Summary of findings

Overall, inspectors found that this was a well-managed centre. Those interviewed by inspectors or who had completed questionnaires spoke highly of the managers and staff team. There was evidence of good care practices in the centre which included focussed work being carried out with the young people. The young people interviewed or who returned questionnaires to inspectors had a good understanding and awareness of their rights and the plans for their futures. The young people's dislikes about the centre were balanced with the positive regard for the staff and the care they received. The staff team were an experienced, long-serving group of professionals. Overall, there was a good level of compliance with standards and regulations.

Key recommendations in this report are in relation to: purpose and function, management and staffing, supervision, monitoring, children's rights, suitable placement and admissions, care planning and reviews, social work role, safeguarding and child protection, managing behaviour, health, premises and safety and fire safety.

Practices that met the required standard

Inspectors found that the following standards were met: primary care, register, notification of significant events, vetting, administrative files and children's care files, contact with families, emotional and specialist support, preparation for leaving care and aftercare, education, insurance and maintenance.

Primary care/daily routines
This standard was met. It was the view of the inspectors that young people were well cared for and that individual needs were catered for. Young people interviewed or who completed questionnaires were very positive about the staff and stated they felt safe and secure in their placement. They could also exercise choice in food, clothing and leisure activities. The centre was aware of the spiritual and cultural needs of the young people and staff facilitated the practice and participation in these. Evidence of this was found in interviews and a review of centre records.

Register
The centre maintained a register on the young people which contained all the required statutory information.

Notification of significant events
The standard on notification of significant events was well met. Social workers and the monitoring officer were satisfied that this was carried out in a prompt manner in accordance with the standard.

Vetting
Overall the standard of vetting was good. Following the last inspection in 2008, Garda clearances had been renewed for long serving staff members.

Administrative Files and Children's Care Files
The centre had an experienced administrative team of eight staff with good recording systems in place. The centre had different formats in place for recording and storing of information about each boy in the centre. Each young person had a permanent and secure care file which was stored in an administration building separate to the residential unit. Inspectors viewed each file and found that they contained the required statutory documentation and other

relevant documentation. The centre had a particular section for the archiving of records of all children placed in the service since it was established. They also had a computerised "student system" which contained a discreet record for each boy.

Contact with families

This standard was well met. Despite geographical distances, access arrangements made in care plans and care plan reviews were honoured and ongoing and frequent contact with parents and carers was facilitated by staff. The children interviewed or who completed questionnaires said they had regular contact with their families and that the centre staff encouraged as much contact as possible. Families were encouraged to visit and stay over in the designated family accommodation. The parents interviewed and/or completed questionnaires told inspectors that they were satisfied with the level of contact and identified the key worker for their child as someone they knew and trusted. Staff with responsibility for aftercare and pastoral care liaised closely with the families.

Emotional and specialist supports

The centre employed a full-time psychologist. She carried out an annual audit of incidents where physical restraint was used as part of Therapeutic Crisis Intervention (TCI), a model of physical intervention approved by the HSE. She also attended statutory reviews, case conferences and other meetings concerning the boys and was a member of the critical incident review group. The psychologist provided support and guidance to staff working directly with the boys, individual work with the boys and liaison with their parents or carers. Staff, parents and young people told inspectors how helpful they found the service she provided.

Those interviewed were aware of the emotional and psychological needs of the young people. Inspectors examined records of good focussed work with individual young people on care files, each with identified key-workers who were responsible for implementing the young person's placement plan.

Preparation for leaving care/aftercare

This standard was met. The centre had two designated units for older boys. One unit was a pre-leaving unit which allowed the boys to be more independent and attain the required skills and knowledge prior to leaving. With the assistance of staff they took responsibility for meal planning, cooking, managing money, meeting friends and engaging in leisure activities external to the centre. The centre also had the facility of a "cottage" on the grounds for boys who were ready to move to semi-independent accommodation.

Education

This standard was well met. The on-site school had proven to be a valuable resource to the centre. The school principal and his staff reported to a local V.E.C. appointed Board of Management. Prior to their admission the majority of boys did not attend school on a regular basis. Managers and staff placed a high value on education, encouraging and facilitating each boy to maximise his educational abilities in conjunction with school staff. Eight of the boys in residence at the time of the inspection had just completed their Junior Certificate examinations. The boys interviewed told inspectors that they enjoyed attending school and wanted to at least achieve their Junior Certificate examinations. They valued access to practical subjects such as woodwork and art, and the level of individual attention and support they received in the classrooms. Inspectors found many examples of excellent working relationships and co-operation between the school and centre staff concerning the general care of the boys. This is commendable.

Insurance
The centre had full valid up-to-date insurance cover. It was covered by the State's Claims Agency for most of the insurance categories. The centre's vehicles tax certificates were up-to-date.

Maintenance
The accommodation for the children, which includes the four separate units and a central refectory, was generally maintained to a high standard by the centre's own maintenance team. The individual houses were of varying standards of décor, but inspectors were told that during the summer holidays when the children are away from the campus, there is a programme of repairs to bring the accommodation up to standard.

There were some maintenance matters outstanding. For example, a TV had been moved from one wall to another, but electric cable was still in position at the old site, and several light fittings were damaged or out of use. In one of the units there was water damage on the ceiling of a shower room and the floor tiles were in need of upgrading.

Practices that met the required standard in some respect only

Inspectors found that the following standards were met in part: purpose and function, management and staffing, supervision and support, training and development, monitoring, children's rights, social work role, discharges, safeguarding and child protection, health, managing behaviour, holiday facility, premises and safety and fire safety.

Purpose and function
The statement of purpose and function stated that the centre could accommodate up to 24 boys aged 11 to 15 years on admission. The centre had transferred from the Department of Education to the Health Service Executive in March 2007. During the last full inspection in 2008, a purpose and function review group was established by HSE senior managers with specific terms of reference including consideration of the future of the centre. Inspectors found during the follow-up inspection in June 2009 that a draft review report was being considered by the then local health manager. However, the outcome of the review was still unclear. Inspectors were of the same view during this inspection and were concerned that the long-standing uncertainty about the centre's purpose for the future was having a negative impact on staff. Inspectors recommend that the future purpose and function of the centre is reviewed by the National Director for Children and Family Services and appropriate change management processes where appropriate are put in place in the centre as soon as possible.

Management and staffing
The centre had a clearly defined management structure. The centre director reported directly to the local HSE area general manager who in turn reported to a local health manager in another area.

The official complement of staff comprised 115.32 whole time equivalent posts. There were 109 staff employed at the time of inspection which included the following:

- the director,
- two deputy directors (one in an acting position)
- four care managers (two in acting positions)
- four unit managers (one in an acting position)
- eight assistant unit managers (four in acting positions)
- forty two child care staff (24 full-time and 18 part-time)
- a pastoral care worker
- an aftercare worker
- fourteen night supervisors (seven full-time and seven part-time)
- a psychologist,
- five catering staff
- twelve general household staff
- four maintenance staff and a driver
- eight administration staff,
- a nurse

The staff team was experienced, long-serving and a committed group of professionals. External professionals and parents interviewed and/or who completed questionnaires spoke highly of the management's and staff's commitment to caring for the young people. Unit/Care managers interviewed told inspectors that they had concerns regarding the level of communication between senior managers and themselves and said they felt excluded from decision making processes. Young people and staff told inspectors that they would like to see the centre directors more throughout the day in each of the units informally. Inspectors urge

the directors to make themselves more accessible to the young people by more informal contact with them in the units. Inspectors advise that the directors invite staff groups to engage in discussions with them on how they might improve communication and decision-making. In general, inspectors found through interviews with staff and unit/care managers that morale amongst the staff group was low, there were a lot of questions in relation to the future of the service (*See Purpose and Function),* and a palpable distance between senior managers and staff on the ground.

While inspectors were satisfied that the centre was well managed, they found that the internal management structure at the time of the inspection was more than was necessary for a mainstream residential service. A review of the management structure should be linked to the future purpose and function of the centre as outlined above. While the inspectors acknowledged that the complexity of the current management and staffing structures were legacies of the centre's past, the fact was that they remained even though the purpose and function had changed and the numbers of young people had declined. Given that the centre provided a diverse and high quality range of services, those interviewed and who completed questionnaires generally believed that the centre was meeting their needs. Inspectors recommend that the internal management structure is reviewed in line with the review of the future purpose and function of the service.

Supervision and support

This standard was met in part. The formal supervision of staff was carried out as follows: the director supervised the two deputy directors, the deputy directors divided the supervision responsibility between them for unit/care managers, maintenance and ancillary staff, psychologist and nurse, and the unit managers supervised the care staff and night supervisors. Staff interviewed told inspectors that they should receive supervision six times a year in line with centre policy. Inspectors viewed a sample of supervision files and found most records had significant gaps and with no record of explanation. The director and one of the deputy director's told inspectors that it had been their practice not to keep records of supervision for many years. Staff meetings were held on a weekly basis and handover meetings occurred at the start of each shift.

Inspectors recommend that:

- the format, frequency and recording of supervision in the centre conforms fully with HSE policy,
- a note is made of the reason why a supervision session does not occur ,
- centre managers put in place a system for monitoring and quality assuring supervision practice.

Training and development

The standard was met in part. All staff were trained in Therapeutic Crisis Intervention (TCI). The majority of staff were trained in fire safety and first aid. During interviews, some staff told inspectors that they either had not done any training in child protection (*Children First: National Guidelines for the Protection and Welfare of Children)* or it had been some years since they had received the training. There had been little turnover of staff since the centre was established and the majority of the staff had been in employment long before the HSE took over the centre.

Inspectors recommend that managers:

- provide training in Children First for the care staff who have either not received it or who require updating as a matter of priority,
- complete an audit of the staff team's training needs, skills and competencies.

Monitoring
This standard was only met in part for the majority of the year prior to this inspection due to the monitoring officer being off on extended leave. The HSE monitoring officer who had visited the centre regularly retired in April 2011. The last monitoring report was dated 10 November 2010. The inspectors were informed by the director that an interim arrangement had been put in place for the notification of significant events and a authorised person had been designated the role temporarily.

Inspectors recommend that the timescale for the appointment notwithstanding, formal arrangements be put in place to ensure that the HSE continues to carry out its monitoring function in respect of the centre as outlined in the Child Care Regulations 1995, Part III, Article 17.

Children's Rights - consultation
This standard was met in part. The staff team were found to be proactive in promoting the rights of the young people. Consultation with the young people took place in each unit on a daily basis. However, there was no written evidence of this, and the young people interviewed told inspectors that the consultation that did occur was not effective. The young people were encouraged to be involved in the day-to-day aspects of the unit. They also contributed to their care planning review meetings, as required by the standards.

Children's Rights - complaints
Complaints made by young people were few. In general, the young people who were interviewed and/or who had completed questionnaires said they were confident in the complaints system within the centre and felt listened to. They also identified individual staff as people they would talk to if they were worried about anything.

Inspectors were made aware of concerns relating to the use of non-routine interventions raised by two young people who were subsequently not returned to the centre by their supervising social workers. The concerns were raised by the young people with their respective social workers and not with the centre director prior to the placements being suspended. These concerns were made known to HIQA prior to the inspection on receipt of information in March 2011 from a HSE monitoring officer in the local health area where the boys had come from. On foot of this information, the inspector wrote to the centre director on the 30 March 2011 requesting further information on the concerns raised regarding the use of non-routine interventions. This request was compiled with fully and promptly. The information received from the centre director subsequently became part of the evidence used during the inspection process.

The director informed the inspectors of how these issues were currently being investigated as there were operational and child protection concerns raised in the original information. Operational issues were reviewed by the centre director and centre management. The child protection concerns were being investigated by a social work team leader. The director told inspectors that a review of compliance with policy was carried out by the management team in the centre resulting in issues regarding "*completion and timely submission of documentation."* Following this review, steps were taken by the director to "*strengthen and improve practice."* The inspectors were given a copy of the outcome of the internal operational review. The child protection concerns were still under investigation by a social work team leader and this was still ongoing at the time of inspection. The inspector will request a status update from the principal social worker in the relevant local health area. *(See also section on Discharges)*

The young people were within their rights to bring their concerns to the attention of their supervising social workers, and it was consistent with the supervising social workers' role for them to make a decision about the continuation of the placements in the light of the information received. The director expressed a concern that the complaints were not brought to his attention prior to the closure of the placements. This is a matter that requires further discussion between the social work department and the centre. The inspectors advise that the complaints system in the centre should be reviewed to ensure that young people in particular have confidence in raising complaints with the centre's managers.

Children's Rights - privacy
Inspectors formed the view that the young people's right to privacy required more consideration, such as: entering the young people's bedrooms without knocking first, the location of the unit telephone in the main hallway, and the use of CCTV inside the units (*See also the section of this report on Accommodation).*

Inspectors were told that the CCTV system had been in place for several years, and that its purpose was to monitor the movements of children at night as a preventive measure. To do this, there was real-time monitoring of the images by the night supervisors on a bank of five screens in each of the unit's work stations. This was seen as helpful to the night supervisors, each of whose work areas were positioned in 'bridge' rooms enabling them to access two units. Inspectors are of the view that the use of CCTV inside the units constitutes an infringement of the children's rights to privacy, is not consistent with good child care practice, and is not appropriate or acceptable inside a children's centre. Its use for routine supervision should cease.

Inspectors were concerned that policy and practice in the use of CCTV in the centre gives supervision precedence over privacy, and they recommend that external managers of the service, in consultation with the HSE National Office for Children and Family Services, review the use of internal CCTV on the premises with a view to removing it as soon as possible. The review should also consider whether the use of CCTV and the records that stem from it conform to the requirements of data protection legislation.

Children's Rights – access to information
In general the young people who were interviewed and/or who completed questionnaires had a fair understanding of how to access their information. Staff were aware of the young people's rights to access information about themselves. However, there was some confusion on exactly what information the young people could access. Each young person's care file was stored in a separate administration building which made it difficult for the young person to access easily.

Inspectors recommend that:

- consultative processes with the young people are reviewed to ensure their effectiveness,
- access to information is reviewed with staff to ensure that young people understand what is contained in care files and proactively explain, encourage and facilitate access for the young people,
- the storage of care files is reviewed to ensure that the young people's right to access to their information is not hindered in any way,
- young people's right to privacy is given greater priority and practices that infringe on privacy are identified and changed to reflect children's rights and best practice.

Suitable placements and admissions

This standard was met in part. External professionals and staff interviewed about this standard expressed varying levels of satisfaction/dissatisfaction to the appropriateness of some placements and admissions. Some of the staff interviewed were not in agreement with some placement decisions despite voicing their opinions within the pre-admission case conference and felt that in several cases a decision to proceed with an admission was to the detriment of the other children in residence and staff. Standard 5.6 requires centres to operate admissions policies that take into account the need to protect young people from abuse by their peers. In general, most staff agreed that the centre met the needs of the young people resident in the centre at the time of inspection. However, there had been a period of significantly extreme challenging behaviour in the latter part of 2010 which resulted in a lot of property damage and violence towards staff. Inspectors recommend that senior managers review the admissions process to include written risk assessments and ensure the policy and practices takes account of the need to protect the young people already in residence.

Social Workers

This standard was met in part. All of the boys had supervising social workers. Inspectors found evidence that social workers attended the required pre-placement, admission and initial case conference and statutory reviews. However, in a number of cases there was little evidence on care files of visits to young people outside of these occasions or of social workers reading care files and centre records. This was a finding of the previous inspection in 2008. During the follow-up inspection in 2009, inspectors found that there had been no significant improvement regarding this despite efforts made by centre management and staff.

Inspectors recommend that:

- the HSE issue a national directive to principal social workers ensuring that (i) all young people in care particularly those placed far from their community of origin are regularly visited in accordance with the regulations and standards and (ii) that during visits to residential centres the supervising social workers read care files and other relevant records from time to time as required by the regulations,
- supervising social workers are provided with a declaration of expectations by the centre consistent with the duties outlined in the regulations and standards.

Care planning and statutory reviews

This standard was met in part. On review of all care files, inspectors found that several initial care plans on file were outdated and it was unclear if care plans had been updated as there were few copies of minutes of statutory care plan reviews on file. Despite this, most of the care plans examined by inspectors were comprehensive and of good quality.

Whilst there was good evidence of internal case conferences and reviews, inspectors could not determine if or which of these meetings were also used as statutory care plan reviews. From interviews with social workers, inspectors found that in some cases a care plan review was carried out in tandem with or at the end of the centre's internal meetings and some were held separately and external to the centre. In examining the care files, inspectors did not find formal aftercare plans for boys aged 16 years and over, as required by the standard.

Inspectors recommend that:

- the centre is furnished with all outstanding statutory care plan review minutes, updated care plans and any other supporting documentation without further delay,
- aftercare plans are prepared for each boy aged 16 years and over in accordance with the standard as matter of priority

Management of behaviour - General
During interviews with staff and external professionals, inspectors acknowledged that the centre provided care for young people with complex and challenging behaviours and that a number of them, due to their criminal offending behaviour both external to the centre and as a consequence of their behaviour in the placement, had come to the attention of the courts. Overall, inspectors found for the majority of boys that the behaviour management strategies in the centre were effective.

All staff were trained in Therapeutic Crisis Intervention (TCI), the HSE approved method for behaviour management. Each boy had an up-to-date individual crisis management plan which was placed in a visible location in each unit staff office. There had been 72 physical restraints in the year prior to inspection involving 19 boys. There were two review groups in the centre: a monitoring group to review all incidents of the use of physical restraint, and a group to review all other significant events. The groups included a deputy director, the centre psychologist, a care manager, the HSE monitoring officer and the area child care manager. Inspectors were informed that this group did not meet regularly for the past twelve months and therefore not all incidents had been reviewed. The reason given was the absence of the HSE monitoring officer due to extended leave. Inspectors recommend that the HSE appoint an independent external person with expertise in TCI to this group in the interest of transparency and objectivity.

The centre used a "ratings system" to encourage and promote good behaviour and positive change. The boys got allocated marks daily by centre and school staff based on their behaviour. At the end of the week the marks determined the privileges the boys could earn, the level of pocket money and bedtime routines for the following week. All boys got some pocket money even if they had sanctions. Overall the boys understood and responded well to the "ratings system" although some boys told inspectors that they found it difficult to achieve "high" ratings. Some staff interviewed told inspectors that no boy would ever reach the top rating as it was designed that way. A similar view was also echoed by the young people during interviews. Inspectors advise that the director resolves the different views amongst the staff and young people in relation to this issue.

Absence without authority
There had been 195 unauthorised absences in the year prior to inspection involving 25 boys. Inspectors found that staff were persistent in engaging with boys who repeatedly left the centre without permission. Unit records showed that the HSE/Gardai protocol for children missing from care was followed. The absences were appropriately notified to all relevant parties, and staff liaised closely with families, social workers and the Gardai in order to address absences with the young people and manage the risk whilst they were absent from the unit. Inspectors recommend that the centre introduces further measures to reduce the incidence of absences from the unit to a minimum.

Discharges
Twenty-two young people had been discharged from the centre in the previous twelve months. In general, these were planned discharges with two unplanned discharges from the centre. In the latter cases, two young people were not returned to the care of the centre as a consequence of concerns raised by the young people to their supervising social workers in relation to the use of time away for the management of behaviour. *(See sections on Managing Behaviour and Children's Rights - Complaints)*

Safeguarding/child protection

This standard was met in part. The centre had a comprehensive specifically locally negotiated child protection policy dated April 2008. It provided for the child care manager of the local health area in which the centre was situated to be notified of all child protection concerns and sign off on completed assessments or investigations of them. The policy complemented good care practices and was drawn up accordance with *Children First: National Guidelines for the Protection and Welfare of Children 1999*. The two deputy directors were the designated child protection officers in the centre and maintained the centre's child protection register. In the twelve months prior to the inspection 10 child protection concerns had been reported to the local social work department, the placing social work departments and other relevant parties. Inspectors reviewed the child protection records and found that the concerns had been dealt with promptly and efficiently. However, the records did not show the level of informal consultation with social workers that took place. In most incidents, a letter was issued to report the concern rather than a standard report form as required by Children First and HSE policy. Inspectors recommend that the child protection reporting procedure is reviewed to ensure that there is a transparent process consistent with national HSE policy and procedures. At the time of the inspection there was one child protection concern outstanding. Inspectors were informed that this had been investigated and had yet to be signed off. Inspectors found through interviews that staff understood and were confident about their duties in relation to the reporting of child protection concerns.

Health

Inspectors were of the view that the boys received a high standard of health care. Each boy had a medical examination on admission and again on discharge. The centre provided a nursing service Monday to Friday and the boys could attend by appointment. The nurse liaised closely with the G.P. practice that attended the centre in response to any medical needs. Each boy had a nursing care plan on their medical records. The boys could choose between two local G.P's or, dependent on geographical distances, could be facilitated to maintain registration with their family G.P. Each young person had a medical card. The local area Care Doc service was available out of hours.

Inspectors were told that the school provided Social Personal and Health Education which included the "Kick the Nic" smoking cessation programme and "Copping On" an anti-offending behaviour programme. This programme was delivered by school and care staff, the psychologist, the aftercare worker, the pastoral care officer and the school nurse. Inspectors were informed by the centre director that smoking was no longer prohibited in the centre. Previous practice in the centre was to pose a fine or sanction on the young people if caught smoking. This was seen as counter-productive. The young people were now allowed to smoke five to six times a day. They were required to hand up their cigarettes and lighters at night. Inspectors witnessed young people smoking in the presence of staff. This was described by some staff as necessary supervision on the grounds of safety. The centre's dedicated nurse told inspectors that she was not in agreement with the change in centre practice regarding smoking. The inspectors were concerned about the practice and recommend that the HSE nationally provide clear guidance to residential centres on smoking by young people.

Accommodation

The centre was the largest residential facility in the country for children in care. It was located on the outskirts of a small town and was purpose built in the late 1980's. It was a large campus based centre with a range of buildings. It comprised four separate residential units, each providing accommodation for five or six boys of similar age. There were a number of auxiliary units and two additional residential units. The site also included a purpose-built and

well resourced school, administration buildings for offices, conference and meeting rooms, a separate refectory, a small two-bedroom bungalow suitable for semi-independent living which had been used for young people prior to leaving the centre, a large laundry, a gymnasium, a swimming pool, an all-weather football pitch, accommodation facilities which were used by visiting parents and families of the children in the centre, and extensive grounds. There was also a chapel which used for religious services which were also attended by members of the local community. During the summer months of July and August, staff and children relocated to a property by the coast owned by the HSE. The overall impression was of a centre that was cared for and well maintained.

Each two-storey unit had a large kitchen/dinging room and an L-shaped sitting room with an open fire. In these rooms there were speakers for a public address system that was operated from the centre's reception block. The unit's laundry had large non-domestic washing machines and dryers. On the upper floor, there were bedrooms, one of which was an en suite room for staff on sleep-in duty. There was also a unit manager's office, bathrooms, and a staff office. In the staff office there was a bed in a recess which was used by the second member of staff on sleep-in duty. This arrangement was unsuitable, and should be reviewed by the centre's managers. Some of the unused bedrooms were used for recreational purposes. For example, one was described as the darts room, another as a play station room, and another simply contained a punch bag.

Outside the back of the units there were sand buckets which were used for cigarette butts and packets. Children were allowed to smoke under the supervision of staff in these areas, and inspectors observed this happening. (See the comments under *Health* above.) One of them was full of cigarette packets and presented a potential fire hazard. Inspectors recommend that this should be recorded in the health and safety assessment as a risk and managed appropriately.

The general décor and furnishings in the children's accommodation were of a satisfactory standard, and, although the structure of the centre is clearly institutional, the children's accommodation was of a reasonable standard for the most part.

One of the units had seen more wear and tear than the others, and staff explained that there had been a period in the year prior to the inspection when the behaviour of some of the children resulted in significant damage to property.

There was ample space for young people to meet visitors, family friends and professionals in private. Each child had his own bedroom. The bedrooms were suitable and adequately appointed. They were not all equally well personalised by the children. This may reflect the fact that placements in the centre are short to medium term. Inspectors noted that the windows of the bedrooms open out fully presenting a risk to the children. The inspector conducting the inspection of accommodation was told that children had occasionally jumped from them. Inspectors recommend that this risk should be recorded in the centre's health and safety assessment and appropriate action should be taken to manage it appropriately. There was ample space and excellent facilities for recreation in the centre.

One of the bedrooms in a unit that was no longer in use was fitted with a urinal and a sink for which the water supply could be controlled by a key. The purpose of this arrangement was to facilitate children giving urine samples for drug analysis by staff. In one instance at the time of the inspection a child was giving a sample for analysis under direction from a court. Inspectors were of the view that this is a practice more in keeping with the centre's previous function as a detention school than with its current role as a children's centre.

The external managers of the service, in consultation with the HSE's National Office for Children and Family Services, should review this arrangement and determine how such requests are to be met in the future.

Holiday facility

Inspectors met with the care staff and children in the holiday house on the 4 July 2011. The house was located on ample grounds beside the sea and had access to local amenities. The building was well maintained and had recently been repainted, re-roofed and new plumbing installed. It resembled a typical holiday home but for its size, as it could accommodate up to 12 boys and nine staff. The boys' bedrooms were dormitory style with three beds in each and an en-suite shower and toilet. There were individual rooms for staff (one with an en-suite facility), a staff office and a manager's office.

It had a large industrial type kitchen and a big open plan sitting room-cum-dining area. There was also a small chapel on site which was used for mass on a Saturday evening. Members of the local community could use this facility during the summer. A large storage container was located in a corner of grounds which stored bicycles, canoes and other recreational equipment. The boys enjoyed a number of activities while on holiday such as cycling, fishing, canoeing, go-karting, soccer, tennis, etc.

A unit manager and staff team took responsibility for a group of young people on a week-to-week rotating basis for the months of July and August. Inspectors found that while the boys enjoyed their holiday period, the routines and practices of the residential centre were fully adhered to; e.g. ratings system for the management of behaviour and the use of a *'time away'* room which was defined as *"any period of time whereby the child is asked to accompany staff to an area to regain control or process and learn from events";* and therefore became an extension of residential care and did not feel like being on holidays as their peers would experience. Inspectors were told that in general the boys' behaviour during their stay in the holiday house was good and never warranted the use of '*time away'.* The staffing regime of the residential centre was also evident; e.g. night supervisors carried out their shifts and used real time monitoring of CCTV footage on the corridors outside the young people's accommodation, the centre's nurse spent one full day each week in the holiday house and a chef/cook was present each day.

While inspectors acknowledge the need to supervise these young people and maintain some order, they were of the opinion that this was far removed from the experience of their peers during holiday time. Inspectors recommend that centre management explore ways to differentiate between the everyday routines and systems of the centre and those of the holiday home, once they remain within the remit of the centre.

Safety

The centre had a designated safety officer and a fire safety officer. There was an up-to-date health and safety statement. Inspectors were provided with evidence that a series of health and safety assessments were carried out in 2010 with the most recent in May 2010. The assessments were thorough, but they identified potential and inherent risks in the facilities and environment rather than immediate hazards. The assessments did not include the use of CCTV cameras on the corridors inside the children's accommodation. (*See the comments under Children's rights – privacy above.)*

Medicines were appropriately stored in wall-mounted locked metal cabinets in staff offices, and the medication administration system, which included regular stock checks and was

overseen by the centre's nurse, was good. Inspectors were told that staff's medication was kept separate from young people. The centre had a clear system and routine for the safe storage of kitchen knives and household chemicals.

In one of the unit kitchens raw and cooked meats were stored unsafely. The centre managers should issue clear guidelines to staff, and arrange for practice in food hygiene to be regularly monitored.

Fire safety
The centre had written confirmation of compliance with all statutory requirements relating to fire safety and building control.

An inspector examined the fire register and found that it did not adequately reflect the fire safety precautions actually in place. It was a loose-leaf folder, and some of the information was not clearly labelled. It is recommended that the centre adopts a fire register that holds all the essential information on fire safety in one secure record. In an inspection of the children's accommodation an inspector noted that the systems for fire safety and fire fighting were regularly serviced. The last check before the inspection was on 26th April 2011. Fire safety training was regularly provided to staff. The most recent session of training was attended by 65 staff on 27th August 2010.

Inspectors were of the view that there was scope for improvement in fire safety practice. There was evidence of irregular fire drills taking place. Inspectors found a written record of 12 evacuations in five years. There had been four quarterly evacuations in 2009; but there were only two (in April and May) in 2010 and one in 2011. In the records of fire drills it was difficult to distinguish between adults and children, and it was not clear beyond doubt whether one child was present on site or away on an access visit. There was confusion in one evacuation when a group of visitors, attending one of the buildings on campus for training, did not know where the assembly point was. Given the size of the campus and the range of buildings, consideration should be given to making the identification of numbers of people on site as simple and accountable as possible. In two of the houses, fire blankets were left on a surface with other items, potentially making them difficult to find when needed. Several rooms were cluttered, and some of the unused bedrooms in the houses were used for storage. One was filled from floor to ceiling with old beds, mattresses and bean bags. Some fire safety issues concerned practice, e.g. in one of the houses fire extinguishers were used as door stops. Inspectors were told that the open fires in the sitting rooms were always supervised when lit. Managers of the centre should arrange for practice in fire safety to be regularly monitored.

Inspectors recommend that, as the centre is a complex of several buildings divided into 13 fire safety zones, the managers should seek advice from the HSE fire safety officer about the frequency, form and recording of fire drills and evacuations. Advice should also be sought about the storage of items in the children's accommodation.

Practices that did not meet the required standard

Managing behaviour - Use of 'Time Away'

The centre operated a '*time away'* policy which was defined as "*any period of time whereby the child is asked to accompany staff to an area to regain control or process and learn from events."* One bedroom in each unit was designated a '*time away'* room. These were bleak, bare rooms without furnishings, resembling cells. They had a non-slip floor, and there was frosted Perspex in the windows. They were at the end of the unit corridors. There were also

two other units available for the purposes of using time away. Inspectors found that in most cases when a young person was placed in "*time away"* the door to the room remained unlocked with a staff member present in the corridor immediately outside. However, inspectors also found that in some cases that the door was locked and/or remained locked for a period of time following a young person being put in time away in a separate building on the grounds. Staff told inspectors that even in instances where the door was unlocked the young person could not leave the room and if they attempted to do so, they would be put back into the room. Records evidenced that Gardai assisted in escorting the boys to this building on several occasions.

Although '*time away'* was described by staff as necessary for the management of difficult behaviour, the use of it and the time away rooms were clearly perceived as punishment by the young people. During the last inspection in 2008, inspectors were concerned about the use of single separation to manage the boys' behaviour. In a letter issued by the Chief Inspector, HIQA SSI to the local health manager on 8 August 2008 it was stated: "*I am requesting that the practice of using single separation (detention of a child) as a routine measure ceases.*" In a further letter from the inspectorate to the manager of the centre on 11 August 2008 it was stated: "*HIQA, SSI have repeatedly stated that there is no legal authority to singly separate children in an open residential centre and it is not in compliance with the National Standards for Children's Residential Centres."*

During this inspection, inspectors were concerned that the practice of '*time away'* resembled single separation as once a young person was placed in a time away room they were not free to come out without the consent of staff, therefore their liberty was taken away. In one twelve month period from March 2010 to March 2011, the total number of time away interventions was 68 involving 14 boys. Twenty of these related to one young person. Twenty-five of these were overnight periods and one young person remained in a separate unit for five days. This was as a result of a cycle of unauthorised absences, extremely reckless behaviour and significant property damage to a unit. Records showed that the young person was initially locked in a room in the separate unit and then given access to the rest of the unit with the external unit doors locked. The director informed the inspectors that this intervention followed a risk assessment and was in accordance with the *Best Practice Guidelines in the Use of Physical Restraint,* and was approved by the parent of the young person, the placing social worker, the placing social worker's principal social worker and the area child care manager.

During interviews, staff and young people were asked about the use of '*time away'* and their understanding of it. Some social workers interviewed were not aware of the time away policy. Inspectors got various responses and views from centre records and interviews as to when a decision was made to enact the policy and how '*time away'* periods were reviewed. In some instances, the use of '*time away'* was described as single separation by both staff and young people.

Regardless of how the policy was carried out, the young people viewed this intervention as being "locked up" and told inspectors that they did not like this. Inspectors were made aware of complaints made by two young people about the use of *'time away'* and who had since been discharged from the centre. (*See section on Complaints).*
Inspectors recommend that:

- the HSE should develop an unequivocal national policy in relation to use of all non-routine interventions used to manage behaviour in open centres
- staff complete clear and detailed records of all physical interventions used and that these are rigorously reviewed by the HSE monitoring officer.

• 3. Findings

3.1 Purpose and function

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Purpose and function		√	

Recommendation:

1. The HSE South should ensure that the future purpose and function of the centre is reviewed by the National Director for Children and Family Services and appropriate change management processes are put in place.

3.2 Management and staffing

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Management		√	
Register	√		
Notification of significant events	√		
Staffing		√	
Supervision and support		√	
Training and development		√	
Administrative files	√		

Recommendations:

2. The HSE South should ensure that the internal management structure is reviewed in line with the review of the future purpose and function of the service.

3. The HSE South should ensure that:
   - the format, frequency and recording of supervision in the centre conforms fully with HSE policy,
   - a note is made of the reason why a supervision session does not occur,
   - centre directors and managers put in place a system for monitoring and quality assuring supervision practice.

4. The HSE South should ensure that:
   - training in Children First is provided for the care staff who have either not received it or who require updating as a matter of priority,
   - complete an audit of the staff team's training needs, skills and competencies

3.3 Monitoring

Standard
The health board, for the purposes of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the health board to monitor statutory and non-statutory children's residential centres.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Monitoring		√	

Recommendation:

5. The HSE South should ensure that the timescale for the appointment notwithstanding, formal arrangements be put in place to ensure that the HSE continues to carry out its monitoring function in respect of the HSU as outlined in the Child Care Regulations 1995, Part III, Article 17.

3.4 Children's rights

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Consultation		√	
Complaints		√	
Access to information		√	

Recommendations:

6. The HSE South should ensure that:
   - consultative processes with the young people are reviewed to ensure their effectiveness,
   - access to information is reviewed with staff to ensure that young people understand what is contained in care files and proactively explain, encourage and facilitate access for them,
   - the storage of care files is reviewed to ensure that the young people's right to access their information is not hindered in any way,
   - young people's privacy is given greater priority and practices that infringe on privacy are identified and changed to reflect children's rights and best practice.

The inspectors advise that the complaints system in the centre should be reviewed to ensure that young people in particular have confidence in raising complaints with the centre's managers.

3.5 Planning for children and young people

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Suitable placements and admissions		√	
Statutory care planning and review		√	
Contact with families	√		
Supervision and visiting of young people		√	
Social work role		√	
Emotional and specialist support	√		
Preparation for leaving care	√		
Discharges		√	
Aftercare	√		

Recommendations:

7. The HSE South should ensure that senior managers review the admissions process to include written risk assessments and to ensure the policy and practices takes account of the need to protect the young people already in residence.

8. The HSE should ensure that:
   - the centre is furnished with all outstanding statutory child in care review minutes, updated care plans and any other supporting documentation without further delay,
   - aftercare plans are formulated for each boy aged 16 years and over in accordance with the standard as matter of priority

9. The HSE should ensure that:
   - a national directive is issued to principal social workers ensuring that (i) all young people in care particularly those placed far from their community of origin are regularly visited in accordance with the regulations and standards

and (ii) that during visits to residential centres the supervising social workers read care files and other relevant records from time to time as required by the regulations,

- supervising social workers are provided with a declaration of expectations by the centre consistent with the duties in the regulations and standards.

3.6 Care of young people

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Individual care in group living	√		
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability	√		
Managing behaviour			√
Restraint		√	
Absence without authority		√	

Recommendations:

10. The HSE South should ensure that they appoint an independent external person with expertise in TCI to this group in the interest of transparency and objectivity.

11. The HSE should ensure that:
    - an unequivocal national policy is developed in relation to the use of all non-routine interventions used to manage behaviour in open centres,
    - staff complete clear and detailed records of all interventions used and that these are rigorously reviewed by the HSE monitoring officer.

12. The HSE South should ensure that further measures are introduced to reduce the incidence of absences from the unit to a minimum.

Inspectors advise that the director resolves the different views amongst the staff and young people in relation to the ratings system.

3.7 Safeguarding and Child Protection

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Safeguarding and child protection		√	

Recommendation:

13. The HSE South should ensure that the child protection reporting procedure is reviewed to ensure a transparent process consistent with national HSE policy and procedures.

3.8 Education

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Education	√		

3.9 Health

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Health		√	

Recommendation:

14. The HSE should ensure that clear national guidance is provided to residential centres on smoking by young people.

3.10 Premises and Safety

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

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Accommodation		√	
Maintenance and repairs	√		
Safety		√	
Fire safety		√	

Recommendations:

15. The HSE South should ensure that the smoking area to the rear of the units be recorded in the health and safety assessment as a risk and managed appropriate.

16. The HSE South should ensure that the bedroom windows should be recorded in the centre's health and safety assessment and appropriate action should be taken to manage it appropriately.

17. The HSE South should ensure that the external managers of the service, in consultation with the HSE's National Office for Children and Family Services, should review the practice of carrying out urinalysis and determine how such requests are to be met in the future.

18. The HSE South should ensure that external managers of the service, in consultation with the HSE National Office for Children and Family Services review the use of CCTV on the premises with a view to removing it as soon as possible. The review should consider whether the use of CCTV and the records that stem from it conform to the requirements of data protection legislation.

19. The HSE South should ensure that centre managers should issue clear guidelines and arrange for practice for unit staff in food hygiene to be regularly monitored.

20. The HSE South should ensure that the centre adopts a fire register that holds all the essential information on fire safety in one secure record.

21. The HSE South should ensure that managers seek advice from the HSE fire safety officer about the frequency, form and recording of fire drills and evacuations.

22. The HSE South should ensure that the centre management explore ways to differentiate between the everyday routines and systems of the centre and those of the holiday home, once they remain within the remit of the centre.

4. Summary of recommendations

1. The HSE South should ensure that the future purpose and function of the centre is reviewed by the National Director for children and family services and appropriate change management processes are put in place.

2. The HSE South should ensure that the internal management structure is reviewed in line with the review of the future purpose and function of the service.

3. The HSE South should ensure that:

- the format, frequency and recording of supervision in the centre conforms fully with HSE policy,
- a note is made of the reason why a supervision session does not occur,
- centre directors and managers put in place a system for monitoring and quality assuring supervision practice.

4. The HSE South should ensure that:

- training in Children First is provided for the care staff who have either not received it or who require updating as a matter of priority,
- complete an audit of the staff team's training needs, skills and competencies

5. The HSE South should ensure that the timescale for the appointment notwithstanding, formal arrangements be put in place to ensure that the HSE continues to carry out its monitoring function in respect of the HSU as outlined in the Child Care Regulations 1995, Part III, Article 17.

6. The HSE South should ensure that:

- consultative processes with the young people are reviewed to ensure their effectiveness,
- access to information is reviewed with staff to ensure that young people understand what is contained in care files and proactively explain, encourage and facilitate access for the young people,
- the storage of care files is reviewed to ensure that the young people's right to access their information is not hindered in any way,
- young people's right to privacy is given greater priority and practices that infringe on privacy are identified and changed to reflect children's rights and best practice.

7. The HSE South should ensure that senior managers review the admissions process to include written risk assessments and to ensure the policy and practices takes account of the need to protect the young people already in residence.

8. The HSE should ensure that:

- the centre is furnished with all outstanding statutory care plan review minutes, updated care plans and any other supporting documentation without further delay,
- aftercare plans are prepared for each boy aged 16 years and over in accordance with the standard as matter of priority

9. The HSE should ensure that:

- a national directive is issued to principal social workers ensuring that (i) all young people in care particularly those placed far from their community of origin are regularly visited in accordance with the regulations and standards and (ii) that during visits to residential centres the supervising social workers

read care files and other relevant records from time to time as required by the regulations,
- supervising social workers are provided with a declaration of expectations by the centre consistent with the duties in the regulations and standards.

10. The HSE South should ensure that they appoint an independent external person with expertise in TCI to this group in the interest of transparency and objectivity.

11. The HSE should ensure that:
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22. The HSE South should ensure that the centre management explore ways to differentiate between the everyday routines and systems of the centre and those of the holiday home, once they remain within the remit of the centre.

Inspectors advise that the complaints system in the centre should be reviewed to ensure that young people in particular have confidence in raising complaints with the centre's managers.

Inspectors advise that the director resolves the different views amongst the staff and young people in relation to the ratings system.