Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE WESTERN AREA

INSPECTION REPORT NUMBER: 431

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Contents

1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Services Executive Western Area (HSEWA). Kieran O'Connor (lead inspector), and Nuala Ward (co-inspector) conducted the inspection under Section 69 (2) of the Child Care Act 1991, on the 24 - 25 November 2010. In the last follow up inspection in July 2009 ID (No329) Inspectors found that of nineteen recommendations, 11 had been met in full, five were met in part and three were not met. Inspectors found that these remaining outstanding recommendations were now met. However, inspectors found that other recommendations that had previously been met were no longer met.

A key recommendation from the first inspection was that major refurbishment and maintenance needed to take place to ensure that the premise was up to standard. This had taken place. However, inspectors found that the centre was poorly maintained again. This inspector returned to the centre again on 1^{t} February and an update of finding is provided at the end of the report.

The centre was a purpose-built residential facility attractively located near the seafront a short distance from the city centre. The centre was an amalgamation of two other children's residential centres in the HSE West region. The purpose of the centre was to provide medium term residential care for four children and young people, boys and girls, aged between 14 and 18 years on admission within the catchment area of Galway Roscommon and Mayo. At the time of inspection, there were two girls aged 15 to 18 years respectively, residing in the centre.

1.1 Methodology

Inspectors' judgements are based on an analysis of findings verified from several sources including: evidence gathered through direct observation of practice, interviews, examination of records and documentation, and an inspection of accommodation, an interview with two young people, two foster parents, the centre manager, a monitoring officer, five child care workers, one social worker, a social work team leader and the acting child care manager and the general manager. Details of sources of evidence are given below. Inspectors also conducted a telephone interview with the local health manager, centres complaints officer, a key worker for one child, the staff consultant and aftercare worker who were not available at the time of inspection.

The inspector had access to the following documents:

- The centre's statement of purpose and function
- The centre's policies and procedures
- The centre register
- The young people's care plans and care files
- Census form on staff
- Census form on young people
- Staff personnel files
- Questionnaires completed by young people, care staff, and social workers
- Administrative records
- Details of unauthorised absences for previous twelve months (95)
- Details of physical interventions for the previous twelve months (0)
- Details of the amalgamation process for the services
- The centres fire register
- Car and building insurance.

1.2 Acknowledgements

The inspectors wish to acknowledge the co-operation of the young people, foster carers, staff and all other professionals who participated in this inspection.

1.3 Management structure

The centre manager reported to the acting child care manager who reported to the general manager for HSE WA who in turn reported to the Local Health Manager.

1.4 Data on young people

The following young people were residing in the centre, listed in order of length of placement:

Young Person	*Age*	*Legal Status*	*Length of Placement*	*Number. of previous placements*
# 1 (female)	15yrs	Full Care Order	1 year 2 months	1 emergency residential care 1 foster care
# 2 (female)	17yrs	Full Care Order	2 months	1 foster care 4 residential care 1 special care

2. Analysis of Findings

Practices that met the required standard

Discharges
There had been four admissions and five young people had been discharged in the twelve months prior to inspection. These were planned discharges in accordance with the standard.

Complaints
The standard on complaints was met. The centre had a good complaints policy. There was a designated complaints officer on the staff team. This is good practice. A central complaints register was maintained. There had been two complaints made by young people in the year prior to inspection. Records indicate that they were notified to the supervising social workers. Inspectors judged that they were dealt with in an appropriate and timely manner. Overall they were very well managed.

Register
The centre had a register on the young people which contained all the information required in the Child Care (Placement of Children in Residential Care) Regulations 1995 Part 1V Article 21.

Insurance
The centre provided inspectors with documentary evidence that they were adequately insured.

Practices that met the required standard in some respect only

Inspectors found that standards were partially met in relation to purpose and function, staff supervision, family contact, care files, children's rights, care planning, aspects of both child protection and aftercare.

Purpose and Function
This standard was met in part. The centre's statement of purpose and function described the centre as an alternative care provision of the HSE Western area offering medium-term accommodation for four young people, boys and girls aged 14 to 18 years on admission. As a regional service it provided placements for three local health areas in the HSE WA.

Inspectors found that this purpose was not reflected in practice. There were three emergency placements in the year prior to inspection. At the time of inspection there was one young person over a year in the centre and her care plan stated that she would remain in the centre for the long term. Another young person had been living in the centre for six weeks but was already transitioning to aftercare and independent living. Inspectors learnt that two of the young people who had moved into aftercare in the year prior to inspection had lost their apartment accommodation and were now living in an adult homeless hostel.

Inspectors recommend a review of the purpose of this centre having regard to the needs of the young people in care in relation to the provision of a flexible and responsive aftercare service within the range of already- established alternative care services in the region. This will be further discussed in the aftercare section below.

Staffing
The standard on staffing was met in part. The majority of staff were suitably qualified and well experienced and the average length of service in the centre was over seven years. Inspectors found that morale among the staff team was uneven. The team lacked cohesion. Some of the staff team felt they were underemployed and unclear about the direction the service was taking while others felt they were providing a good service to the young people in their care.

Vetting
The standard on vetting was met in part. Inspectors were informed prior to inspection that all the staff team working in the centre had Garda Síochana vetting and the required references. However, there were not the required three references on file in some cases. Inspectors found that some of the personnel records had no record of Garda vetting. In other personnel files there was a letter from the HSE human resources section stating that they had received the required clearance. Inspectors advise that this is insufficient. As recommended in the previous inspection, Inspectors recommend that files are organised for ease of access and a record of Garda vetting is held on file.

Staff Supervision and support
The standard on supervision was met in part. There was a commitment to supervision and staff support. All the files reviewed contained individual staff supervision contracts. This is good practice. Inspectors examined a sample of records and found that formal supervision was not occurring frequently enough. There were gaps of five months in some cases. There was generally an emphasis on the needs of young people and the support and development of the staff team. However, given the difficulties in relation to managing some aspects of the young people's behaviour, as part of supervision, more emphasis should have been placed on finding imaginative ways of engaging with them and developing stronger relationships with young people in the centre. Inspectors recommend a review of the content of formal supervision contracts. The centre

managers receive formal group supervision by the acting child care manager on a monthly basis. Inspectors judged that group supervision is valuable but insufficient. The centre manager needs to receive regular individual formal supervision with her line manager as required by the childrens standards and best practice.

Team meetings were occurring on a weekly basis. However, there were very few staff at some of the meetings. Inspectors recommend that attendance at team meeting is increased. The centre had the services of a child care consultant for in-house staff consultation. This was carried out with the team on a fortnightly basis. The consultant's task was to assist staff in working with the children and communicating in a focussed and planned manner. Those interviewed generally spoke positively about the consultation process. Considering that this service constituted a significant financial commitment by the HSE WA, inspectors were concerned that these consultations were not having a significant impact on the care and management of behaviour in relation to the young people in the centre. This will be further discussed in the management of behaviour section below.

Contact with families

Inspectors found from staff and family interviews and centre records that, in general contact with families was good. Young people told inspectors that they had contact with their parents, siblings and extended family where appropriate. Inspectors found evidence that there was good forward planning for family access and detailed arrangements had been put in place to ensure siblings would be together for Christmas. Parents and foster carers were notified of all significant events where appropriate. However, two foster carers for one child told inspectors that they believed their child's psychological needs as recommended by a comprehensive psychological report were not being fully met in this residential placement and the young person was not ready for a plan for independent living. They complained that their views were not listened to by the centre or the HSE social work service. Inspectors recommend that their complaint is reviewed by the HSE West.

Administrative and care files

The standard on care and administrative files was met in part. Each young person had a care file. Inspectors found that there were good recording systems in place reflecting the day to day operations in the centre. However, some medical information was not on file. The content and organisation of the care files, log books and other records was of good standard and were written in a respectful tone. Inspectors advise discontinuing the use of the word resident, and just refer to children or young people living in the centre. Inspectors advise that some of the recording in the log book could be a little more succinct.

A significant psychological report was not on the case file of one young person and inspectors recommend that this is acquired and placed on the care file in order to inform the case and care planning. One of the disused bedrooms was used as a storeroom for the care records of children and young people who lived in the centre in the past. This storage was not secure enough. Inspectors recommend that files are archived in secure storage in perpetuity as required by the standards.

Children's Rights

The standard on children's rights was met in part. The young people told inspectors that they were informed of their rights on admission and they were given a booklet outlining these rights. They could name a staff member they could talk to if they were worried about anything. Key workers were assigned to each young person. It was centre policy that generally young people were consulted about all aspects of their lives and facilitated to give their views at care plan review meetings. Inspectors found there were some very good key working sessions recorded. The young people were consulted about school and training courses. However, one young person

told inspectors that she had expressed a wish to return to school some time ago but at the time of inspection this had not been followed up. Inspectors found her request verified by centre records. Young people were also involved in drawing up a weekly menu. They were assisted in preparation for their statutory review meetings and given opportunities to express their views.

Inspectors found that formal house meetings with the young people were taking place on a regular basis. Inspectors perused the minutes of young peoples meetings in the past year and found that in some cases they were young people orientated but in other cases the agenda was dominated by staff issues. The challenge for staff is to ensure that their own agenda does not pre-dominate this forum and to broaden the scope of the meeting so that the young people have opportunities to engage in significant problem solving, negotiation, and decision making particularly in relation to issues that have a direct impact on their lives. Inspectors advise that it is important that the agenda should reflect the young people's issues and interpersonal relationships in the centre could feature as a significant standing item. Inspectors recommend a review of the content of young peoples meetings.

There was a practice in the centre of staff supervision of young people's telephone conversations. This is not acceptable practice. Unless contra- indicated by court order or risk assessment, young people have a right to make telephone calls in private. Inspectors recommend that the practice of supervising telephone calls in the centre is reviewed. The young people told inspectors that they had no access to a computer in the centre. Inspectors recommend that the centre policy on the use of computers is amended to comply with the standards.

The young people were not very clear about accessing information held on their files. The HSE WA had organised training for the staff team but for reasons mainly to do with the work surrounding the amalgamation of the centres this had not occurred. Inspectors perused the training material that had been prepared and it was of good quality. Inspectors advise that it would be important to include the psychological and welfare benefits of sharing information with young people about themselves in addition to their legal right to information. As recommended in the last inspection in 2008 and outlined in the centre policy, inspectors recommend and that the centre manager ensures that all staff understand the policy and can explain the process to the young people. The young people were not aware of the organisation; *The Irish Association of Young People in Care (IAYPIC)* who are inter ilia an advocacy group for children in care. The association had visited the centre in the past. Inspectors recommend that the IAYPIC are invited to the centre again to meet with young people.

Social work and Care Planning

The standard on social work and care planning was met in part. Both young people had social workers who visited them regularly and saw them privately. The social workers read the care files from time to time as required by the standards. However, inspectors were concerned that one very vulnerable young person had a succession of three social workers in the past 18 months contrary to best practice. The young people understood the role of the social workers and generally valued contact with them. One young person felt very supported by her social worker. However one young person felt that the social worker was always "just bringing bad news". This view was also brought to the inspectors' attention by the social worker. Inspectors recommend a more partnership focused approach between the care staff and social worker in sharing, both positive and challenging, information with young people.

All the young people had a care plan and they were regularly reviewed. However inspectors had concerns about the strategic comprehensiveness of one after care plan. One of the young people was nearing her 18th year and the plan was for independent living in an apartment supported by

the aftercare service. Inspectors had two concerns about the care plan. Firstly, given the current needs of this particular young person, inspectors judged that it was unrealistic that the young person would be ready for independent living within the timelines recorded in the after care plan. Secondly there was no default position in the plan if it did not succeed. The young person herself told inspectors that she was not ready for the move and was afraid of becoming homeless if the plan did not work out. Inspectors recommend a further care plan review in which the guiding principals include listening to the views of the young person and a realistic assessment of her needs.

Inspectors were seriously concerned that both young people were leaving the centre frequently, engaging in risk-taking behaviours and associating with people known to the Gardaí. Both young people had been assaulted while in this undesirable company. Given the very risky behaviours the young people were engaged in inspectors recommend an increase in social work contact to closely monitor and address this. Inspectors recommend that every effort is made to decrease the level of unauthorised absences in the centre. If there are ongoing serious risks for these very vulnerable young people these placements need to be reviewed. This will be commented on further under child protection.

Preparation for leaving care and aftercare

The standard on after care was met in part. The HSE WA had a policy on aftercare provision. It stated that "*the primary legislative framework for the development of services for care leavers is contextualised within the Child Care Act l991. Article 45 of this Act outlines the discretionary power of Health Boards to provide assistance to young people leaving the care of the Board for as long as it is needed up to the young person attaining the age of 21 years".*

Inspectors found that there was a belief among the young people, centre staff, social workers and senior managers that young people had to leave the centre when they reached 18 years of age. This belief was reinforced by the fact that the aftercare plan was due to commence on the day of one young persons 18th birthday. Inspectors were told that this after-care practice was supported by the fact that this was also the day when the care order terminated. There was a further belief that the provision of aftercare was at the discretion of the HSE WA.Some professionals told inspectors that after care was available provided the young person was in full-time education.

Inspectors advise that the Child Care Act 1991 states that the HSE may provide aftercare. The use of the word **may** gives the HSE positive permission to provide an aftercare service. Any discretionary power applies only to the young person in relation to availing of an after care service and **not** the HSE in providing it.

The Minister for Children and Youth Affairs issued correspondence to the HSE in June 2010 regarding the provision of after care to young people following legal clarification on the Child Care Act 1991. The correspondence stating the following; "*in order to remove any doubts in this regard and in accordance section 45(4) of the 1991 Act the HSE are directed to formulate and implement appropriate administrative procedures and guidance for implementing said duty".*

The directive goes on to state that the HSE should have regard to the recommendations of the Ryan report implementation plan which states that the provision of aftercare by the HSE should form an integral part of care delivery for children who have been in the care of the state. It should not be seen as a discretionary service or as a once off event that occurs on a young persons 18th birthday. Inspectors recommend that this directive is implemented.

In practice, the provision of after -care in the HSE WA was very good in some aspects. There was a discrete after- care service based in the city nearby employing three dedicated aftercare workers. One young person told inspectors that she found this service very helpful. Inspectors found evidence that some young people involved in the aftercare service and some who were no longer using the service and were doing reasonably well. However, some other young people were not doing so well. At the time of inspection two young people who had been living in the centre in the year prior to inspection were now either sporadically living in an adult homeless hostel or sleeping rough. Inspectors recommend a detailed review of the progress of young people who had left care in the HSE WA region in the past three years.

The aftercare service was linked in with many other agencies in the provision of aftercare such as the community welfare service and the housing department. The aftercare service had also linked with the Jigsaw Project, a new community based independent service which offered an integrated social work, medical, psychiatric and psychological services for vulnerable young people. It also had an informal drop in centre. This was a very good development in the aftercare service.

Inspectors found that the centre subject to this inspection was already involved informally in aftercare with young people who lived there in the past. Some of the staff team in the centre were still in touch with some of the young people formerly in their care. Inspectors commend some of the staff team for their knowledge of and commitment to those young people. This connection was particularly valuable in the evening and weekends as although there was one aftercare worker available there was no formal on call, out- of- hours after care service available in the HSE WA.

The centre itself could be modified to develop a semi- independent living service that could form an integral part of the after care service. Inspectors recommend that the centres purpose and function is reviewed. The HSE WA should revise the purpose and function for the centre and devise a role for this centre within the range of alternative care services.

Child safety and protection

The standard on child safety and protection was met in part. The staff team interviewed by inspectors had a good knowledge of centre policies and national guidelines on child safety and protection and were clear about how they would act in the event of concerns about the safety of children. There were six child protection notifications in relation to two young people in the past six months. These concerns were about young people leaving the centre and placing themselves at serious risk at times associating with adults well known to the gardaí. Inspectors found that these were managed appropriately in accordance with Children First: National Guidelines for the Protection and Welfare of Children. However Inspectors were particularly concerned that one young person had returned to the centre after an alleged assault, serious enough to warrant the provision of statement to the Garda. There was one child protection conference called in relation to one young person. Another young person returned to the centre having been drinking alcohol dishevelled and distressed with leg injuries that warranted a visit to the hospital.

On another occasion, a young person allegedly witnessed another serious assault. Inspectors brought these serious concerns to the attention of the general manager and the child care manager at the time of the inspection visit. Given the level of risk involved inspectors recommend these placements are reviewed and risk assessed as a matter of urgency within the forum of a child protection conference.

Fire Safety
The standard had been met in part. The centre manager had written confirmation from an architect that all statutory requirements relating to fire safety and building control have been complied with in as required by standard 10.19. Fire equipment and the fire alarm and security system had been checked. Fire drills had been taking place.

There was a practice of locking the front and back doors at dusk and there was no fire key on display. This needed to be risk- assessed from a fire safety perspective. There was no evidence that a fire blanket had been checked. The fire extinguishers were locked away in the office because of difficulties with young people who previously lived in the centre. Inspectors recommend that the procedure of locking the front and back doors at dusk and locking fire extinguishers in the staff room is risk assessed from a fire safety perspective.

Practices that did not meet the required standard

The standard was not met in relation to care and group living, management, notification of significant events, education, health, monitoring, behaviour management and aspects of accommodation.

Care and group living
Overall, the standard on care and group living was not met. The centre was not well kept or maintained. This will be further elaborated on in the premises section. The young people in the centre said they were unhappy living in the centre. They described themselves as lonely. The young people got up late, did not attend school or training and there was no routine or structure to their day. They were regularly going out without permission and putting themselves at risk. The young people said they were bored and felt "crowded out" by adults in the centre. One young person said that they felt some of the staff cared about them they and some did not. Inspectors observed that there was insufficient interaction between the young people and some of the staff team. The monitoring officers told inspectors that they found a lack of an atmosphere of openness and warmth in the centre. The young people said some of the staff team "just lock themselves in the office go on the internet and refuse to come out". They said other members of the staff team "just talk to each other are not interested in us and only chat to us when we do something wrong".

They liked the food but said there wasn't much variety. They said that "they don't get asked to do the shopping and get different things". One young person said that she wanted a staff member to go to the gym with her but nobody volunteered. The young people talked to inspectors about their interest in studying psychology, beauty courses and French. One young person said she wanted to go back to school but nothing happened and "I am bored and fed up most of the time". Inspectors noted that these were the personal expressions of the young people feelings regardless of the veracity of their perceptions.

On the other hand inspectors found evidence that the staff team handled a sensitive family matter that had the potential to be very stressful involving one young person very well. Both young people spoke warmly of and could name a member of the staff team they felt cared for them listened to them and whom they trusted to complain to if they were worried about anything. One young person described a staff member as "genuine, keeps promises and easy to talk to about anything". The young people liked their bedroom where they choose their room colour and had pictures of their family and their favourite music bands on display. They can also choose their own clothes.

Both young people told inspectors that they cannot make a phone call in private. They said there was no computer available to young people in the centre. All the young people were worried about their future. They said they were frightened that they could be homeless as they heard that this happened to other young people who had formerly lived in the centre. One young person said that she experienced special care as a better placement because "there's loads do all day, all the staff talk kindly, make you want to do well and they would go out and get you a smoothie and have one with you. You learnt how to cook nice things and the staff would eat the food you cooked with you". These responses require serious review by the management and the staff team.

Inspectors recommend a review of the approach to caring for young people in the centre.

Management

The standard was not met. There were 21 staff posts comprising a qualified and experienced manager and deputy manager, one social care leaders, 15 social care workers, of which 11 were permanent and three were relief, a part- time administrator and a housekeeper. At the time of the announcement of the inspection the manager was on sick leave for a number of months. However by the time of the fieldwork visit she had recently returned to work and made herself available for interview as part of the inspection.

Staff and other professionals external to the centre told inspectors that both the manager and the deputy manager were dedicated and committed to the children in their care. One young person said that "the managers cared and had a warm family way about them, a kind of motherly love".

Some aspects of the management of this centre had been subject to a serious anonymous written complaint in the past year. This had been investigated by a senior external manager within the HSE in the past few months and the finding were that the complaints were not accurate or valid and the staff who were the subject of the complaints were exonerated. However, the fact of the investigation caused stress and tension among the management and staff team and in cases a number of members the staff team lost their focus on the needs of the children.

The manager and deputy manager had different abilities and strengths. In some cases these differences can harmonise and enhance each others effectiveness. However, this was not occurring in this case. The differing management styles contradicted rather than complemented each other. There was a lack of clarity about their respective roles and responsibilities and consequently some routine but important managerial tasks such as regular staff supervision and some aspects of the physical management and maintenance of the centre were left undone when the manager was on sick leave for a couple of months.

Staff told inspectors that they had been given contradictory guidance and direction at times. For example some staff understood that if the investigation already referred was raised by inspectors, they were to tell inspectors that they need to discuss this with senior HSE managers external to the centre. Other staff told inspectors that if questions were asked about the investigation they were to be honest and open about it. To illustrate the point further, some of the staff team told inspectors that children who had been living in the centre in the past could return to visit the centre. Others told inspectors that these children could not visit the centre as they would not be covered by HSE insurance anymore.

Inspectors were told that these management tensions were overt and consequently all staff were aware of the tension between the management of the centre. This poor governance and oversight in the centre led to a failure to meet some very basic standards already referenced in this report. This caused the centre to lose direction in relation to some aspects of the care of the

young people. Inspectors brought their concerns about this management conflict to the attention of the acting child care manager who was line manager for the centre. The acting child care manager had already initiated meeting between the management team to address this.

Inspectors recommended that this management problem is addressed and concluded as a matter of priority.

Notification of significant events
The standard was not met. The centre had a clear system for the notification of significant events and records of those notifications were maintained. However, external professionals interviewed were not satisfied that at times notifications were made in a prompt manner. Some significant events that were clearly of concern in relation to the welfare of the young person and other events of a sensitive legal nature were not interpreted as significant by the centre staff. Inspectors recommend further training and direction to the management and the staff team in what constitutes a significant event.

Behaviour Management and unauthorised Absences
The management of behaviour was not met. Inspectors found from records and interviews with the staff team and the young people that at times the team related well to them and this was an important factor in gaining the young people's confidence and cooperation in the centre. Inspectors were told that the approved method of managing behaviour used within the centre was Therapeutic Crisis Intervention (TCI) and that de-escalating techniques were the main focus of managing behaviour. There were no physical restraints in the centre in the year prior to inspection. There was evidence of risk assessments and each of the young people had an individual crisis management plan (ICMP). However, given the level of risky behaviour involved when young people leave the centre, the risk assessments need to be reviewed.

Staff and young people interviewed told inspectors that the use of sanctions for the management of behaviour had not been effective. Staff were struggling to deal with the young people who were not attending any substantial education or training courses and there was no structure to their day.

There had been 95 unauthorised absences involving five young people in the year prior to inspection. The centre maintained a record of instances when young people went missing from the centre. The centre used the HSE Garda Siochana protocol for reporting young people missing and measuring levels of risk associated with these instances. Some of the absences were of short duration of two hours or less. However, some absences involved a number of days and on one occasion a young person was missing for two weeks. The young people were at times involved in inappropriate and high risk activities with adults known to the Gardaí.

As already stated, the centre had the services of a child care consultant. Inspectors recommend that the consultant focuses work on improving relationship building and daily routines in gaining cooperation and managing behaviour. Inspectors recommend that every effort is made to decrease the level of unauthorised abscesses from the centre. This was also discussed under child protection due to the serious risks the children were subjected to when absent fro the centre.

Education
The standard on education was not met. None of the young people were in full- time education or training. One of the young people was sporadically attending one class for two hours a week. Efforts were made to secure a school place for this young person but this had not occurred. A placement had been secured with FAS for young person in January 2011 but the commencement date was unspecified. Another young person had difficulties in school and was suspended over

eleven months ago. Consequently she had not completed her junior certificate last year. The Education Welfare Service had been informed. Some home tuition hours had been secured for her and a new application had been made for next year, but this was inadequate. The young person had expressed a wish to return to school but there was no evidence that this was rigorously followed up. Given the importance of education for self confidence and the future life of young people it is important that the staff team are unrelenting in their efforts to ensure that young people are involved in education or training.

Health

The standard on health was not met. Both the young people had a named general practitioner and a medical card. There was no evidence of a medical assessment on admission to care or note on file in one case outlining why it was unnecessary as required by the regulations. There was no medical history and immunisation records on files despite the fact that both young people had lived in the centre for significant periods of time considering current and previous placements and previous. Inspectors could not find evidence that efforts were made to obtain the information. As recommended in the last inspection in 2009, the medical/health files should be reviewed and the HSE should ensure that efforts made to obtain medical information are recorded on file.

Inspectors found evidence that one child returned to the centre in need of medical assistance for injuries to her legs. Instead of one of the three adult staff members on duty that day accompanying the child to the accident and emergency unit, a taxi was called and the child went to hospital in the taxi alone. This is very poor professional practice. A 15 year old should not be going hospital alone in these circumstances for basic reasons of care and welfare and especially when there were alternative options available. Secondly if a specific medical intervention was required the child was not in a legal position to give consent. On another occasion staff were concerned about a medical issue and accompanied another young person to hospital but had no conversation with the medical professionals either before or after the consultation, in order to inform themselves about medical opinion and treatment.

Inspectors were concerned about the level and extent of cigarette smoking by young people living in the centre. There was no record on file outlining a cessation programme or evidence of efforts to positively discourage them from smoking. While mindful of the need to give children and young people a choice in the preparation of the weekly menu, inspectors were concerned to find the lack of variety and instant nature of the food available in the weekly diet. Inspectors recommend that the staff team positively encourage young people to live a healthy lifestyle by providing a more nutritious and balanced diet. Inspectors recommend a review of the role of the staff team in relation to the medical care and treatment of children and young people in their care.

Monitoring

The standard on monitoring was not met. The previous HSE WA monitoring officer visited the centre on a regular basis in the past and had written comprehensive reports. Copies of the reports were made available to the centre manager, the staff team, the line manager and the general manager.

However, the monitoring officer retired in December 2009. He was not replaced some 11 months later. In April 2010 an informal request was made by the HSE WA to the monitoring officers in HSE South that they would “keep an eye on the centre”. Two monitors visited the centre on two separate days, 28 October and 4 November 2010. During the two days in which staff and the deputy manager were interviewed no mention was made of a significant investigation into aspects of the centre that were potentially pertinent to the welfare of the young people. The monitoring officers told inspectors that they did not find there was sufficient clarity among the

staff team about their role as monitoring officers. Inspectors asked managers and the staff team why the monitors were not informed of the investigation and were given a variety of reasons including that they were not sure of the formal status of the monitoring visit or they were not certain that knowledge of the investigation was within their remit. Inspectors had serious concerns about this lack of clarity.

Inspectors advise that anything that impacts on the welfare or happiness of children in any way comes within the remit of the monitoring officers. Inspectors judged that this confusion among staff and management in the centre reflects the unreliability and inherent danger of informal monitoring arrangements.

In order to be clear that all monitoring visits are official, inspectors recommend that in future a formal written request is made to the relevant HSE senior managers. Inspectors further recommend that a monitoring officer is appointed in order to fulfil their statutory function as required by the Child Care (Placement of Children in Residential Care) Regulations 1995, Part 111, Article 17.

The HSE monitoring officers were not from this area. Inspectors were told that as part of the monitoring arrangement they had to travel to the centre and for financial reasons could not stay overnight locally. The marginal saving did not compensate for shortening the monitoring time in the centre and could impact on the quality and thoroughness of the monitoring function. Inspectors recommend a review of this arrangement. Inspectors further recommend that the ten recommendations arising out of the monitoring inspection are implemented in an expeditious manner.

Accommodation

The standard on accommodation was not met. The centre was a purpose-built residential facility attractively located near the seafront a short distance from the city centre. It had a large back garden. In the last full inspection in 2009 inspectors found "it was in a poor state of décor. Its general appearance and upkeep was poor". Inspectors were told by the acting child care manager that the HSE WA had spent €45000 on the centre's refurbishment and this was completed by the time of the follow up inspection in May 2009. Inspectors are mindful that the centre was damaged recently by young people, some of whom no longer live in the centre. However, inspectors found that the centre appearance had fallen into abeyance again and was not up to the standard again as expected of a home for children and young people.

There was graffiti on the walls at the entrance to the centre. While the centre was clean on the ground floor it was unkempt in some of the currently vacant rooms upstairs. There was a disused fish tank with stale putrid black water in it. There was graffiti on the walls of the empty bedrooms. These rooms had been vacated some months ago and yet they did not have a clean appearance. One of the girls' rooms had a broken mirror on the wall. Another bedroom had no wardrobe and needed to be painted. The window blinds were broken in the young people's bedroom and there were no curtains in the kitchen or the utility room. There were broken pool cues lying around a poolroom. The requirement that the centre is maintained and cleaned to an acceptable standard is not a resource issue and the expectation is that staff are unrelenting in maintaining and cleaning the centre. It is the young people's home.

Inspectors recommend that the external line manager conducts a review on why this basic standard was not met in this case and what steps are taken to ensure it does not recur and ensure that the SSI is furnished with a written report of findings within one month of the publication of this report. One of the bedrooms was used for storing files. This was subject to a previous recommendation.

The property of children who no longer live in the centre was stored in black refuse sacks in one of the disused bedrooms. This is not acceptable. Inspectors recommend that this property is stored in more respectful way such as in suitcases and a plan is put in place with timelines to return the children's property to them. Given the serious nature of the findings outlined in this report. Inspectors will conduct a follow up visit of this centre within three months of the publication of this report.

Update since the inspection fieldwork- November 24 and 25 2010.

A visit was made to the centre by the inspector on the 1st February 2011 due to the level of serious failure identified prior to the publication of the inspection report. The Inspector met separately with the young people, the centre manager and the child care manager and had a telephone interview with the local health manager.

This inspector found that there had been a meeting between the childcare manager and the managers and staff team in the centre where issues outlined in this report were conveyed to the centre team as a matter of serious concern. The staff team were met on an individual basis by the social care leader to discuss these findings. This inspector perused minutes of a one- day review of the service facilitated by the team consultant where the failure to meet the standards outlined was fully discussed, and there was now a renewed commitment by the staff team to provide the best possible service to children in their care.

The young people told this inspector that things were better since the last inspection visit. The centre manager had read the draft inspection report in conjunction with the young people and had agreed to address their concerns immediately as part of the implementation of the report's recommendations.

One young person had commenced studying psychology in a college of further education and the other young person was now receiving nine hours home tuition which she was enjoying pending a full- time placement in the FAS course commencing shortly. One young person told this inspector that although she would prefer to be with her family, the staff team were now making a big effort to make her feel at home in the centre. The young people told the inspector that they were now involved in the weekly grocery and food shop. The inspector noted that the young people now had a more nutritious and balanced diet. The menu was planned on a weekly basis in consultation with the young people.

One young person was now going to the gym with a member of the staff team. The other young person was in the process of transitioning to aftercare and although she was anxious about this, her aftercare plan had been changed to anticipate and allow for any difficulties in the future. The HSE reviewed the purpose and function and it was now changed, and the centre was now part of the aftercare service for children who had been in residential care in the HSE WA. Management issues in the centre were in the process of being addressed. Formal supervision was far more planned. A HSE monitoring officer had now been appointed. All children who had formally lived in the centre had now received their personnel property. The care files of these children were now in secure files and a plan was in place to place them in an external HSE storage facility. There was now clear guidance for staff to address medical issues with the young people. The Irish Association of Young People in Care had been invited to visit the centre and meet with young people.

There had been a major refurbishment of the centre since the beginning of the fieldwork. The centre was very clean and bright. It had been repainted and the bedrooms looked bright with new beds and furniture. Two rooms had been modified to function as a semi-independent

apartment containing a bedroom en-suite and a kitchen for one young person. Both young people were now subject to weekly risk assessments in relation to their safety outside the centre and there was ongoing liaison with the gardaí. There had been a significant decrease in unauthorised absences from the centre. A child protection conference had been arranged in one instance as recommended in this report. This inspector has ongoing concerns about unauthorised absences and recommends that the HSE ensures that if unauthorised absences continue there is a review of this young person's placement.

Of the thirty one recommendations made in this report, significant progress has been made by the HSE to address them. Inspectors will visit the centre again within three months of the publication of this report to ensure compliance with all the recommendations.

3. Findings

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 WA should revise the purpose and function of the centre and agree on the role of this service within the range of alternative care services.**

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 (including vetting)		√	
Supervision and support		√	

Training and development		√	
Administrative files		√	

Recommendations:

2. **The HSE WA should ensure that the management issue in relation to the centre is addressed as a matter of priority.**

3. **The HSE WA should ensure that the personnel files are organised to allow effective management and ease of access and that all staff have the required garda vetting and three references on file in the centre.**

4. **The HSE WA should ensure that the centre manager receives individual formal supervision as required by the standards and best practice.**

5. **The HSE WA should ensure that all staff employed in the centre receives formal and regular supervision in line with the centre policy and records maintained.**

6. **The HSE WA should ensure that staff attendance at team meeting is increased.**

7. **The HSE WA should ensure that all medical information for young people is obtained and placed on their care file.**

8. **The HSE WA should ensure that a completed psychological report for one young person is furnished to the centre.**

9. **The HSE WA should ensure that the centre managers and staff team receive further training in what constitutes a significant event and adhere to the centre policy on reporting significant events**

10. **The HSE WA should ensure that care files are archived in secure storage in perpetuity as required by the standards.**

3. Monitoring

Standard
The Health Service Executive, 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 Service Executive 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			√

Recommendations:

11. **The HSE WA should ensure that a monitoring officer is appointed as a matter of priority in order to fulfil their statutory function as required by the Child Care (Placement of Children in Residential Care) Regulations 1995, Part 111, Article17.**
12. **The HSE WA should ensure that the ten recommendations arising out of the monitoring report in November 2010 are implemented in an expeditious manner.**

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:

13. **The HSE WA should ensure that the centre policy on the use of computers is amended to comply with the standards.**
14. **The HSEWA should ensure that there is a review of young peoples meetings.**
15. **The HSE should ensure that the practice of supervising telephone calls of young people in the centre is reviewed.**
16. **The HSEWA should ensure that the policy on access to information is reviewed and that all staff understands the policy and can explain the process to the young people.**
17. **The HSE WA should ensure that IAYPIC are invited to the centre to meet with young people.**

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		√	
Discharge	√		
Aftercare		√	
Children's case and care records		√	

Recommendations:

18. The HSE WA should ensure that the foster carer's complaint is addressed.

19. The HSE WA should ensure there a partnership approach between the care staff and social workers in working with young people.

20. The HSE WA should that the directive issued by the Department of Health and Children in relation to aftercare provision is implemented.

21. The HSE WA should ensure that a further care plan review is conducted for one young person as outlined in the inspection report.

22. The HSE WA should ensure that social work visits to the centre are adequate to meet the needs of the young people and support the care placements in the centre

23. The HSE WA should ensure that there is a detailed review of the progress of young people who had left care in the HSE WA region in the past three years.

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:

24. The HSE WA should ensure that every effort is made to decrease the level of unauthorised absences in the centre.

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:

25. The HSE WA should ensure that a children protection conference occurs in relation to the young people living in the centre.

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			√

Recommendation:

26. The HSE WA should ensure that young people living in the centre attend training or educational programs.

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			√

Recommendations:

27. The HSE WA should ensure that the medical/health files are reviewed and ensure that efforts are made to obtain absent medical information is recorded on file.

28. The HSE WA should ensure that the staff team positively encourage young people to live a healthy lifestyle by providing a more nutritious and balanced diet.

29. The HSE WA should review the role of the staff team in relation to the medical care and treatment of children and young people in their care.

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 (Placement of Children in Residential 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:

30. The HSE WA should ensure that the external line manager conducts a review of the standards of maintenance and hygiene not met in the centre and what steps are taken to ensure this does not recur.

31. The HSE WA should ensure that the practice of locking the front and back doors at dusk and locking fire extinguishers in the staff room is risk assessed from a fire safety perspective.

4. Summary of recommendations:

1. The HSE WA should revise the purpose and function of the centre and agree on the role of this service within the range of alternative care services.

2. The HSE WA should ensure that the management issue in relation to the centre is addressed as a matter of priority.

3. The HSE WA should ensure that the personnel files are organised to allow effective management and ease of access and that all staff have the required garda vetting and three references on file in the centre.

4. The HSE WA should ensure that the centre manager receives individual formal supervision as required by the standards and best practice.

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