Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Follow-up Inspection Report of a Children's Residential Centre in the Health Service Executive South Area

Inspection Report ID Number: 544
Fieldwork Dates: 18 April 2012
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Centre ID Number: 100

Introduction

The Health Information and Quality Authority's Social Services Inspectorate (SSI), carried out an announced follow-up inspection on 18 April 2012 under Section 69(2) of the Child Care Act 1991. Prior inspections had been carried out in January 2009 ((Report ID 284), June 2009 (Report ID 367), August 2011 (Report ID 482), and January 2012 (Report ID 510).

The purpose of this inspection, carried out by Patrick Bergin (Inspector Manager), Tom Flanagan and Patricia Sheehan (Inspectors), was to further assess the extent to which the recommendations made in previous inspection reports had been implemented. The findings from the recent follow up inspection of the 16 January 2012 (Report ID 510) were that there were serious issues regarding the capacity of the centre to meet the needs of the young people as many actions, identified by the Health Service Executive (HSE) in their response to recommendations made in the 11 August 2011 inspection, had not been implemented. Specifically, 10 of the 15 recommendations, which related to management and staffing, the planning for and care of young people, and children's rights had not been met.

The Authority re-issued the action plan of the 16 January 2012 inspection report to the HSE to address the deficits and requested from the HSE by 3 February 2012 a three-month strategic plan to address the management, staffing and care needs of the young people. The plan received by the Authority did not fully address all the issues raised by the Authority.

Methodology

Due to the serious issues regarding the ongoing capacity of the centre to meet the needs of the young people, the Authority undertook a further follow up inspection on 18 April 2012. Judgements were based on evidence from several sources gathered through direct observation, access to care files and administrative records, the HSE monitoring officer's reports and interviews with the interim manager, the deputy manager, a social care leader, and three staff members. Telephone interviews were conducted with the HSE monitoring officer and inspectors met with two young people. Following the fieldwork a meeting was held with the deputy manager and the child care manager with responsibility for children's residential centres in the area.

Findings

There were four young people on the centre's register. Two of these young people were living in the centre at the time of this inspection visit. One was in school and doing well in their education and one was not in school. The third young person had recently moved to a foster placement and the fourth young person to a private children's residential placement. The most recent visit by the HSE monitoring officer had taken place on 4 April 2012 under Article 17 of the Child Care (Placement of Children in Residential Care) Regulations 1995. There were four recommendations made and these related to the staffing of the centre, notification of significant events and the need for specialist support in the centre.

Inspectors found that of the 15 recommendations made by the Authority in the 11 August 2011 inspection, the recommendations relating to management and staffing, planning for and care of young people, and children's rights had been met in part. A project management team had been established and were developing policies and procedures as part of a revised statement of purpose with the aim of clearly defining the service to be provided in the centre. Evidence of this work in progress was submitted to the inspection team. However, management and staffing structures had not improved at the time of this inspection and remained inadequate to effectively deliver the best possible care and protection for young people.

The centre manager was in an acting position and remained on indefinite leave with the deputy manager acting as the person in charge since January 2012. Due to various forms of

staff leave in situ, there was not a social care leader on each shift to provide leadership and direction and there was evidence of a high use of agency staff. Supervision and support to staff members were directly impacted by these staffing deficits and this was confirmed by staff in interviews. Inspectors were told that the centre was not functioning as a mainstream residential services unit and that they saw no difference from when the centre was a high support unit prior to January 2012. One staff member told an inspector that they had received no supervision since February 2012, that their designated supervisor was now on long-term leave and that no arrangements had been put in place to provide an alternative supervisor.

There was evidence that an audit of training and skills had been commenced. Inspectors were told that questionnaires had been circulated to all members of staff but that some of the completed questionnaires had not yet been returned. There was no evidence of analysis of the completed questionnaires.

A review of care files by inspectors found that statutory care plans were not up to date as required by the Child Care (Placement of Children in Residential Care) Regulations 1995, Part V, Articles 25 and 26. Inspectors viewed copies of emails, which were sent from staff in the centre to the young people's social workers on the morning of the inspection, requesting up to date care plans. There was no evidence available at the time of inspection of regular care plan reviews that demonstrated decisions made and that assessed the effectiveness of the care plan in terms of achieving the desired objectives.

Placement reviews were carried out on a monthly basis. However, as the statutory care plans were not up to date, there was no effective link between the long-term plan and the plan for the young person while in the centre. Individual crisis management plans for the young people had not been updated since January 2012. There was no evidence of national guidance provided to the centre on the issue of smoking by young people as had been recommended on previous inspections.

The care files were disorganised and, in the case of one young person, two files were in use concurrently. Records of meetings were not maintained in sequence and some documentation, such as placement review records, was duplicated. Some important documents, such as the report on a recent incident, were not maintained in the care file but on computer only. In two care files, the sections on education and individual crisis management plans contained no documentation.

Care files did not reflect an accurate record of all information pertaining to child protection concerns. Inspectors were told of the ongoing management of child protection concerns relating to one young person; however, this was not evident on that young person's file. Inspectors viewed a child protection referral relating to another young person and a serious concern regarding the behaviour of an adult individual outside of the centre. There was no evidence of follow up to this child protection report and the action taken to ensure the safety of the young person.

Inspectors viewed the log of unauthorised absences and found that the number of unauthorised absences had been reduced significantly since the previous inspection and, in particular, for one of the young people. However, the issue of achieving a balance between the supervision of the young people and the young people's right to privacy had not been resolved. A staff member told an inspector that staff were confused about this issue and that, while some staff felt that they had a duty to prevent a young person from leaving the centre, other staff felt that the young people had the right to do so if they wished. The staff member said that the deputy manager had addressed this issue with some staff in the weeks prior to the inspection.

A fire safety register had been commenced on 31 January 2012. Documentation was in place to show that the fire alarm was serviced on 27 March 2012 and that a fire evacuation exercise had taken place on 26 March 2012. A weekly inventory of fire fighting equipment was being maintained. Daily checks on the fire alarm and weekly checks on the fire doors had been recorded for several weeks but had not been continued after 13 March 2012. The fire register did not contain a record of any fire drill or fire safety training.

Concerns/new issues

On the day of inspection inspectors found evidence of serious behaviour management issues in the centre. Inspectors were told there had been a number of recent episodes of serious assaults by the young people on staff members. The deputy manager had been on leave and an interim management arrangement was in place. An incident report relating to the events occurring on 1 April 2012 had not been completed and the incident had not been formally reviewed. A second incident on 9 April 2012 had also not been reviewed and inspectors were told that this incident necessitated Garda Síochána intervention and the temporary removal of three girls from the centre by the Garda. Records show that on 10 April 2012 there was another assault on staff which necessitated Garda Síochána intervention and the removal of one of the young people from the centre following a court hearing. Inspectors had concerns about the overall level of safety in the centre, given the high level of stress emanating from the recent events, the numbers of permanent staff available to work, and the capacity of the centre to meet the needs of the young people residing there. This concern was shared by staff in interviews with inspectors and in discussion with the HSE monitoring officer.

Following this inspection, the HSE was asked to consider the present situation and to develop an immediate plan of action to deal with the issues of management, staffing and the care of young people in the centre.

HSE SA response

The Authority was advised on the day of the follow up inspection that the centre will close temporarily for a period of three months. Alternative provision for the two children currently residing in the centre is being sourced by the HSE social work department. Correspondence was issued to the Authority indicating the actions to be taken by the HSE to implement an immediate action plan. The HSE also outlined its intention to address the management and staffing structure deficiencies in the centre and to establish a plan to remedy other compliance issues identified by the Authority.

Health Information and Quality Authority response

Given the level of concern regarding this centre, the Authority considers the decision to cease operation to allow for fundamental structures to be put in place appropriate and necessary. A follow up meeting was held with the Child Care Manager with responsibility for children's residential centres in the area and the centre deputy manager on 23 April 2012. Inspectors were updated on the implementation of the immediate action plan. Inspectors were told that a suitable placement for one young person was identified and the HSE were awaiting confirmation from the provider that the young person would be offered the placement. Alternative options were being explored by the HSE for the second young person and the Authority were to receive updates on these placements.

Next step

The Authority will continue to monitor the implementation of the immediate action plan to address the current situation. Prior to the further placement of young people in the centre, the Authority are seeking assurances from the HSE that the centre is in full compliance with the Child Care (Placement of Children in Residential Care) Regulations 1995 and the *National Standards for Children's Residential Centres 2002*. Further inspections will be undertaken by the Authority as part of its monitoring function following the placement of young people in the centre.