Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Social Services Inspectorate

# A

# CHILDREN'S HIGH SUPPORT UNIT

# IN THE

# HSE SOUTHERN AREA

# FINAL REPORT

***INSPECTION REPORT ID NUMBER: 238***

**Inspection Fieldwork 7th and 8th of July, 2008**
**Publication Date: 22nd October 2008**
**SSI Inspection Period: 10**
**Centre ID Number: 100**

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# 1. Introduction

The Health Information and Quality Authority (HIQA), Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's high support unit in the Health Services Executive (HSE), Southern Area (SA) under Section 69 (2) of the Child Care Act 1991. Mary Tallon (lead inspector) and Sharron Austin (co inspector) carried out the inspection over a two day period from the 7th to the 8th of July, 2008.

The unit was a large modern purpose built unit with a large garden, located in a city suburb. It provided a regional service to the HSE Southern area.

The written statement of purpose and function provided to inspectors described the unit as providing short to medium care for five girls aged 12 to 18 years. At the time of inspection there was one young person living in the unit whose planned admission commenced three days prior to inspection.

## *1.1 Methodology*

The inspection was carried out against the *Child Care (Placement of Children in Residential Care)* regulations *1995 and the National Standards for Children's Residential Centres, 2001.* In this inspection, inspectors' judgements are based on analysis of findings verified from several sources of evidence gathered through interviews, with HSE staff members and management, observation, a review of records and an inspection of accommodation.

The inspectors had access to the following documents during the inspection: the units statement of purpose and function, policies and procedures, the young persons' care file and census form, details of unauthorised absences and physical restraints in the year prior to inspection, a questionnaire completed by the young person, her parents and the supervising social worker, census forms for management and staff, administrative records, health and safety records and confirmation of insurance.

In the course of fieldwork the inspectors interviewed the line manager for the unit, the acting unit manager, the acting senior child care leader, three child care staff, the supervising social worker and the co-ordinator for residential services. The inspectors also interviewed the monitoring officer and spoke with a parent by telephone.

## *1.2 Acknowledgements*

Inspectors wish to acknowledge the co-operation of the young person, her family and HSE management and staff in the inspection.

## *1.3 Management structure*

The unit was managed by the acting unit manager, supported by a deputy manager, and an acting senior child care leader. At the time of inspection the acting unit manager reported to the child care manager of the North Lee Local Health area in the HSESA, who in turn reported to the general manager for that area.

### *1.4 Data on children*

On the first day of fieldwork the following young person was residing in the unit.

| Young Person | Age | Legal Status | Length of Placement | No. of previous placements |
|---|---|---|---|---|
| # 1 (girl) | 15 | Voluntary care | Three days | None |

### *1.5 Data on children in placed in the unit in the year prior to inspection*

| Young Person | Date of admission | Date of discharge | No. of days in unit |
|---|---|---|---|
| # 1 | 16/03/07 | 18/08/07 | 155 |
| # 2 | 18/07/07 | 04/09/07 | 48 |
| # 3 | 16/08/07 | 30/06/08 | 319 |
| # 4 | 25/09/07 | 31/03/08 | 188 |
| # 5<br>(this young person had two separate admissions to the unit) | a)17/04/07<br>b) 29/08/07 | a) 01/06/07<br>b) 07/12/07) | 45<br>100 |

## 2. Analysis of Findings

The unit had previously been inspected by the SSI in June 2005 and the majority of the recommendations arising from that inspection were met. In this inspection, standards on staff qualifications, staff vetting, monitoring, contact with parents, premises, filing systems and administration were met. The standards on complaints, managing behaviour and safeguarding and child protection were not met. Overall inspectors found that the quality of primary care in the unit was good.

Inspectors were told that the centre had not operated to full capacity for some time. Inspectors found that the level of occupancy of the unit was 37% for the year prior to inspection. Inspectors' considered the significant under use of the unit and questioned the efficient management of resources.

Since the unit had not operated to full capacity in the year prior to inspection, inspectors found it difficult to carry out a comprehensive inspection against all the standards, especially the standards on children's rights, planning for young people, care of young people, safeguarding, education health and admissions.

Inspectors recommend that senior HSE managers review the unit's value for money as a matter of priority.

### *Practices that met the required standard*

*Staff checks*
Practice in relation to staff vetting was good with staff having garda clearance and the required three references.

*Register*
The unit had a register that was well maintained but inspectors recommend that details of the onwards placement of young people is recorded in accordance with the regulations.

*Administrative files*
The young people's care files contained all relevant documentation in an accessible format. The standard of record keeping and filing was good.

*Training & Development*
The majority of the staff team were qualified and the HSESA had a policy of supporting staff in seeking a qualification. However, inspectors were told that a joint initiative that was established between the HSESA and a local Institute of Technology to address the issue of unqualified staff working in residential centres in the region was no longer available to staff due to financial constraints. Inspectors recommend that continued support is made available to ensure all staff gain a formal qualification in child care. There was a range of in-service training courses available to staff which child care staff

attended in the year prior to inspection. All of the staff team had been trained in the use of therapeutic crisis intervention (TCI) and the required refresher training was on going.

*Monitoring*
The monitoring officer who took up position five months prior to inspection visited the unit monthly and produced monitoring reports detailing his findings and recommendations. Staff were familiar with the role of the monitoring officer and he told inspectors that he was notified of all significant events. Inspectors were concerned that a recommendation made by the previous monitoring officer eight months prior to inspection, concerning delays in concluding an investigation into a child protection complaint, was only concluded in the weeks prior to inspection. This matter will be discussed later in the report.

*Care files*
The young people's care files were well maintained.

*Primary care/aspects of daily living*
Considering the young person was admitted three days prior to inspection, inspectors found a good level of primary care. She had her own bedroom which she decorated in her choice of colour and personalised with pictures and personal items. She had access to the kitchen and had choice of food, clothing and outings and received pocket money. Inspectors observed staff responding and communicating with the young person in a sensitive and respectful manner, recognising her individual needs.

The health needs of the young person were attended to and inspectors found evidence of a comprehensive health plan.

A plan was in place to meet the educational needs of the young person and she attended a school attached to a residential high support unit.

*Contact with parents*
This standard was met.

*Emotional and Specialist support*
The unit had access to specialist services in the community and also had access to the services of a dedicated psychology service for residential services in the area which comprised two senior psychologists. One of the psychologists had moved to another position within the HSE and had to reduce his input into this area. The second psychologist took on the extra units as a result.

*Premises and Safety*
A health and safety assessment was carried out in the months prior to inspection and all recommendations were implemented in a timely manner. Staff carried out the required fire equipment checks and held regular fire drills. The unit had written compliance relating to fire safety and building control in accordance with *Standard 10.19.*

## *Practices that met the required standard in some respect only*

*Purpose and function*
The written statement of purpose and function provided to inspectors described the unit as providing short to medium high support care for five girls aged 12 to 18 years. The acting centre manager and child care manager said the centre had capacity for five young girls but has never operated to full capacity. The number of referrals/admissions has fluctuated and predominantly the capacity has been two young girls. Inspectors recommend that senior HSE managers address the significant under use of the unit and review the capacity of the unit to care for three or more children including a retrospective view on usage over the past two years. The outreach work currently undertaken by some team members was not reflected in the statement of purpose and function.

Inspectors were told that a written document outlining a model of care to be used and adopted was circulated to the staff team in the weeks prior to inspection. This model of care was developed by psychology staff assigned to work with residential services in the area. Inspectors found little evidence that staff understood the units' model of care. A high support unit can not operate in the absence of an agreed model of how care is to be provided. Inspectors recommend that managers ensure that the agreed model of care is introduced as a priority. This was a recommendation of the previous inspection report.

*Management and staffing*
The staff team comprised the acting unit manager, a deputy manager, an acting senior child care leader and 14.55 whole time equivalent child care posts. Due to the low number of admissions, four staff members were seconded to work with a former resident, and two staff were redeployed following a health and safety assessment. Some staff were identified to carry out outreach work with young people at risk in the community. In addition some staff were redeployed for specific shift cover in residential centres who were experiencing staff shortages or to provide shift cover in emergency situations.

There were three staff on shift nightly, two awake and one sleeping. There were two child care staff and three managers on duty in the daytime. In the four months prior to inspection there was only one young person resident in the unit. During this time there were no referrals for the unit. An increase in outreach work took place as outlined above. Inspectors were made aware of a union directive regarding a work to rule instruction to staff.

Inspectors were concerned that the current staff ratio in the unit was too high for the young person, given her particular needs. Inspectors recommend that senior management review staffing levels to ensure an efficient use of resources.

While the weekly staff roster allowed for a full attendance at staff meetings, inspectors were told that in the months prior to inspection attendance at weekly staff meetings was low and unsatisfactory. Inspectors were told that priority was given by some staff to attend staff meetings if the agenda items referred to staff issues. Inspectors recommend

that all staff attend team meetings as part of their weekly rostered hours in accordance with the *Standard 2.15.* on effective communication, team working and accountability.

Two of the three personnel on the centre management team were in acting positions. Inspectors are of the view that strong management and leadership is essential in the delivery of high quality care to vulnerable children and young people. Inspectors recommend that the HSE ensures that the unit is led and managed effectively.

*Supervision and support*

The acting unit manager had monthly supervision with the line manager and had regular informal contact with him by phone or at meetings. He attended monthly meetings with managers from other residential centres and received professional support from the T.C.I training co-ordinator in the area. While staff told inspectors they received regular supervision which they experienced to be supportive, inspectors found little evidence of recorded formal supervision. Inspectors recommend that the key functions of supervision, management, accountability, and professional development, are addressed in supervision and that it is recorded in accordance with *Standard 2.13.*

*Planning for young people suitable placement*

In the year prior to inspection, five young people had been admitted to and discharged from the unit. Inspectors found that referrals to the unit had fluctuated and there was a period in the year prior to inspection where there were no applications for placements.

The unit had clear admission procedures. These were followed in the admission of the young person in the days prior to inspection. The young person and her family had visited the unit and had met with her key worker prior to her admission and had regular contact with the social worker. The young person had a comprehensive placement plan devised by the unit. Inspectors commend the unit for the quality of the placement plan format which the unit had developed. Since the young person had not been in the care of the HSE prior to her placement in the unit three days prior to inspection, her child care plan was being developed.

Inspectors did not review the suitability of a high support unit for one child who had no previous care history and advise managers to satisfy themselves that it is appropriate.

*Children's rights*

The policy in this area was satisfactory. It was difficult to make an overall judgement as there was only one young person in the unit (on her third day); however, staff said that young people could access their daily records and have access to information and reports written about them. The unit operated a key worker system and the young person could convey her wishes and make requests through her key workers and she did so. A unit staff member held the role of children's rights officer and there was a dedicated section in one of the communal rooms set up for children's rights and relevant information was posted on it.

## *Practices that did not meet the required standard*

*Complaints*
The unit had a complaints' policy and inspectors saw evidence of complaints made by young people that were dealt with appropriately. However, inspectors found evidence of a complaint about a serious child protection matter made by a young person nine months prior to inspection which took six months to conclude. Inspectors could find no evidence that the young person, who no longer resides in the unit, was advised of the outcome. This matter is also referred to in the section on safeguarding and child protection. Inspectors recommend that complaints are dealt with in a timely and responsive manner, and young people are informed of the outcome.

During the inspection the unit line manager told inspectors that an external Monitoring Officer had agreed to act as an external complaints officer and plans were being made for him to visit all residential units in the region in the weeks following inspection.

*Managing behaviour*
In the six months prior to inspection, there were two unauthorised absences and physical restraint was used on one occasion. Inspectors considered that it was difficult to evaluate the effectiveness of behaviour management strategies with such a low population.

Staff told inspectors that the unit had gone through a difficult period in the year prior to inspection and staff morale had been low. This was at a time when the deputy manager and the acting senior child care leader were on leave. While an external child care leader was brought in to support the acting manager during this period, inspectors were told that it coincided with internal staffing issues. At this time the young people presented with challenging behaviour.

Inspectors found that in the summer prior to inspection behaviour management strategies were not effective. During this period three young people were leaving the unit without permission and staff used physical restraint on 24 occasions over a four month period. Some young people left the unit to engage in activities that put themselves at risk. Inspectors found evidence that staff had difficulties in establishing appropriate measure to reduce serious risk behaviours exhibited by the young people. Staff described this period as "very bad and difficult". They told inspectors that there were significant internal staffing issues which were not resolved and staff thought this impacted on the young people. Inspectors noted that there was a significant number of unauthorised absences (38) and incidents of the use of physical restraint (26) in respect of the three young people resident in the unit at this time. External managers should note the probable connection between management absence, low staff morale and the young people's disruptive behaviour.

*Safeguarding & Child Protection*
Staff had a good awareness of safeguarding and all but one staff had attended training in *Children First, National Child Protection and Welfare Guidelines, 1999*. Inspectors were concerned that a serious complaint made by a young person of a child protection nature took six months to reach a conclusion. The complaint was unfounded.

Inspectors found no procedure in place during this period to put interim protective strategies in place to ensure the safety of the young people whilst awaiting an investigation of the complaint. External managers should ensure that staff receive the necessary direction and guidance in this matter. Inspectors recommend that the HSE revises its safeguarding practices to ensure that complaints made by a young person, of a child protection concern, are responded to promptly. Unit managers should give the necessary direction and guidance in responding to such complaints.

Inspectors wrote directly to local HSE managers concerning the issues outlined above.

# 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 | | √ | |

**Recommendations:**

1. The HSE SA should ensure that senior HSE managers review the unit's value for money as a matter of priority.
2. The HSE SA should ensure that senior HSE managers address the significant under use of the unit and review the capacity of the unit to care for three or more children including a retrospective view on usage over the past two years.
3. The HSE SA should ensure that the proposed model of care is introduced as a matter of urgency.

## 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:**

4. The HSE SA should ensure that senior management review staffing levels to ensure an efficient use of resources.
5. The HSE SA should ensure that the unit is led and managed effectively.
6. The HSE SA should ensure that all staff attends team meetings as part of their weekly rostered hours in accordance with the *Standard 2.15.*
7. The HSE SA should ensure that all the functions of supervision are carried out and recorded in accordance with *Standard 2.13.*

## 3.3 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 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 | √ | | |

## 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 | √ | | |

**Recommendation:**

8. The HSE SA should ensure that complaints are dealt with in a timely and responsive manner, and young people are informed of the outcome.

### 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 | **Not inspected** | | |
| Aftercare | **Not inspected** | | |

** Inspected on the basis of one child only (to verify)*

### 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 | | √ | |

**Recommendation:**

9. The HSE SA should ensure that external managers note the probable connection between management absence, low staff morale and the young people's disruptive behaviour.

### 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:**

10. The HSE SA should revise safeguarding practices to ensure that complaints made by a young person, of a child protection concern, are responded to promptly. Unit managers should give the necessary direction and guidance in responding to such complaints.

### 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 | √ | | |

### 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 | √ | | |

## 4. Summary of recommendations

1. The HSE SA should ensure that senior HSE managers review the unit's value for money as a matter of priority.

2. The HSE SA should ensure that senior HSE managers address the significant under use of the unit and review the capacity of the unit to care for three or more children including a retrospective view on usage over the past two years.

3. The HSE SA should ensure that the proposed model of care is introduced as a matter of urgency.

4. The HSE SA should ensure that senior management review staffing levels to ensure an efficient use of resources.

5. The HSE SA should ensure that the unit is led and managed effectively.

6. The HSE SA should ensure that all staff attends team meetings as part of their weekly rostered hours in accordance with the *Standard 2.15.*

7. The HSE SA should ensure that all the functions of supervision are carried out and recorded in accordance with *Standard 2.13.*

8. The HSE SA should ensure that complaints are dealt with in a timely and responsive manner, and young people are informed of the outcome.

9. The HSE SA should ensure that external managers note the probable connection between management absence, low staff morale and the young people's disruptive behaviour.

10. The HSE SA should revise safeguarding practices to ensure that complaints made by a young person, of a child protection concern, are responded to promptly. Unit managers should give the necessary direction and guidance in responding to such complaints.