A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE Dublin Mid-Leinster

FINAL REPORT

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ADDRESS: Social Services Inspectorate, 3rd Floor, Morrison Chambers,
32 Nassau Street, Dublin 2
PHONE: 01-604 1780 FAX: 01-604 1799
WEB: www.issi.ie

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1. Analysis of Findings

The Social Services Inspectorate carried out an unannounced inspection of a children's residential centre in the HSE Dublin Mid-Leinster area under the provision of Section 69(2) of the Child Care Act 1991.

The centre was located in a purpose built detached building in a rural area on the outskirts of a large town. At the time of the inspection there were two teenage girls, a teenage boy and a younger boy living in the centre. The written purpose and function stated that the centre provided medium to long term care to girls and boys between the ages of 8 and 12 on admission. The young people had been living in the centre for a number of years.

This service was originally inspected in 2000 and the report can be accessed on the SSI website as inspection report number 4. The SSI also visited the centre in September 2005 and carried out a day long interview with the unit leader to assess the standard of care in the centre. The main finding from this interview was that the standard of care was good but building was in a poor condition. At the time of this inspection funding had been allocated to complete the necessary renovations and work was due to start within the month.

Overall, inspectors found that the standard of care was good and the staff team were committed to the well-being and care of the young people. The standards which were not met or met in part had consequences for the care and safety of some of the young people. The main areas which required improvement related to standards on staff supervision and support, care planning, management, safeguarding and child protection.

Practices that met the required standard

Primary Care
Inspectors found that the primary needs of the young people were well met by the staff team. There was a good standard of individual work with the young people with their keyworkers and inspectors observed warm interactions between the young people and staff members. Their health needs were well met and case files contained detailed medical histories. The young people's bedrooms were personalised to their own tastes and friends were encouraged to visit. There were consulted about activities and encouraged in their interests in music lessons and sporting activities. External professionals commented on the commitment of the staff team in supporting the young people in following their interests.

Meals were of a good standard and the staff team and young people ate meals together. The inspectors observed good primary care practices by way of regular homework times, provisions of snacks and checking in with the young people about their well-being.

The young people had access to specialist services as required and three out of four young people were in full time education. There was good practice in preparing one young person to live independently.

Management and staffing
The unit leader (local centre manager) was appropriately qualified and was employed in a permanent capacity. She had introduced a new approach to care in the centre which relied on a therapeutic approach based on attachment theory and psychodynamic principles. The manager had an academic qualification in the area of therapeutic care and introduced this approach into the centre two years previously. The young people considered the rules in the centre to be generally fair and also experienced the staff team as caring towards them.

The line manager, with responsibility for two residential centres, visited monthly and occasionally attended staff meetings. She provided monthly supervision to the unit leader. There was an external consultant available to the team on a fortnightly basis to discuss their work with the young people. The external consultant did not have a role in supervising the new therapeutic approach to care but supported the manager in implementing the model through the fortnightly meetings.

The centre had a sufficient number of staff. There were 15½ posts in the centre covered by 19 staff members. Five of the staff had worked in the centre for over ten years. Nine had worked in the centre for less than ten years but more than five years. There was one unit leader and five child care leaders. The centre had two waking night staff at all times and generally a minimum of three staff members on each shift during the day. There was a stable staff team in the centre until recently due to staff transfers to other residential centres in the area. The standard on vetting of staff was met.

Eight of the staff team had qualifications in social studies and social care. Five of staff team had qualifications in related disciplines. The HSE area had recently introduced a new induction programme for staff members.

The HSE area offered a good programme of training for staff members in a variety of areas related to residential care such as child protection, management of challenging behaviour through the Therapeutic Crisis Intervention model, supervisee training and cultural and diversity training with an emphasis on working with children with a traveller background.

Children's rights
There was a good standard on children's rights and both staff members and young people understood the process for making complaints and accessing their files. The centre had weekly community meetings which staff members and young people attended. These meetings were introduced as part of the therapeutic approach. They provided a regular time for young people and staff to discuss day to day issues. These meetings were perceived as very positive experiences by the young people and staff members alike. Inspectors attended one of these meetings and found that the manner it which it was conducted was an empowering experience for the young people and was commendable. Children's rights in the centre would be enhanced by developing a relationship with the Irish Association of Young People in Care.

The staff team had a good understanding of safeguarding practice and also the process for notification of absences with authority. Care files were well-maintained and included the young people's educational achievements.

HSE Monitoring
The HSE's monitoring officer had completed a monitoring visit in April. The inspectors were told that the resultant report was still in draft stage but the centre had implemented some changes based on the verbal feedback. The monitoring officer was also is in the processing of reviewing the discharge of one young person from the centre. This review had delayed the finalisation of the draft report but inspectors were told that both reports would be finalised in the coming weeks.

Social Work
Social workers were in regular contact with the young people through visits and phone contact with the centre. The social workers had good relationships with the young people and were considered as significant people in their lives. One social worker was a strong advocate for the young people she had responsibility for in the centre. Parents and young people attended care plan review meetings and were consulted by social workers and care staff prior to these meetings. Parents told inspectors that minutes of these meetings were sent to them by social workers.

Fire safety
There was good practice in fire safety and the centre had a fire certificate and fire drills occur on a regular basis.

Practices that met the required standard in some respect only

There were some practices in the centre that met the required standard in some aspects only. These were care planning for children under twelve, family contact, maintenance of a register, management, staff supervision and support, notification of significant events, child protection and the management of behaviour.

Purpose and function
The purpose and function of the centre was to provide medium to long term care to children aged between 8 and 12 years on admission to enable them return to their families or to go to foster care. In practice, although the age of admission was being adhered to, inspectors were concerned that there was insufficient attention to the work required to returning children to birth families or placing them in fostering.

Working with families
The unit leader and line manager told inspectors that parents were welcomed in the centre. There were parents' booklets available with information on the centre and two parents visited the centre on regular occasions. One parent had never visited the centre and did not know where the residential centre was. Another parent had visited but did not know any of the staff by name. Both of their children had lived in the centre for a number of years.

It was a matter of concern that relationships had not developed between the centre and these families. Considering the young age of the children when they come into the centre, a concerted commitment to involving families is extremely important. Parents should be integrated into the care of the centre through regular contact by staff members, invitations to visit, forwarding of school reports and invitations to attend school meetings. Two of the parents were unhappy about some aspects of the care of their children but did not know who to contact about their concerns.

Care Planning
The standard on care planning was uneven. All of the children had care plans. Although all of the children a care plan review in the last year, two had no care plan reviews over a two year period. Annual reviews are minimum requirements for children who have been in care for over two years. Inspectors were of the view that annual care plan reviews were inadequate in maintaining the momentum necessary if a return home or foster placement was to be achieved. One social worker told inspectors that young people under 12 were not given the same priority for foster placements as children in the community as once they are in residential care they are not considered as not being at risk. Inspectors urge that fostering social work teams and community social work teams do not inadvertently deprive a child a chance to a family life on the basis of their placement in a residential care setting.

Inspectors were concerned that the use of annual care plan reviews and the lack of focused placement plans impacted on the quality of planning for the young people.

The general manager told inspectors that tenders had recently been sought to facilitate the recruitment of specialised foster parents in the local area.

A befriending family was sourced for one young person but was ended by the family due to concerns about the young person's behaviour in the centre. The HSE should support the use of befriending families through clarifying the expectations of their role in the life of the child, the type of support available to maintain the relationship and how difficulties and endings of the relationship are managed.

Child Protection
The HSE had serious concerns about the lifestyle of one young person including risks related to threats to their well-being from people outside the centre and an inappropriate relationship with an adult male.

A multi-disciplinary child protection case conference was convened to address these concerns and the meeting decided that the young person would be discharged from the centre to live independently in a flat in the locality with staff support for some hours each day.

Inspectors were told by the social worker and line manager that supported accommodation with staff on site was the safest place for the young person but this option was not available. The young person had lived in this centre for six years and had done extremely well in school and in the centre until six months before the inspection when things began to deteriorate. In the overall span of six years, six months is a short time for a young person to experience, for whatever reason, the loss of both their education and their home due to their behaviour.

Inspectors were concerned that a placement decision was made in a child protection case conference plan rather than in a care plan review meeting. The actual decision was also of concern to inspectors as it resulted in the young person being discharged from their home of a number of years to live independently in a flat. The young person was not attending an educational or employment placement and staff would only be available during the day. This was a significant move for any young person and was questionable considering the risks to her well-being in the community.

The relationship between the young person and the adult male in the community was not managed appropriately. Although this relationship was discussed at the child protection conferences, the plan of action was ineffective.

The process for managing incidents with child protection concerns within the centre also needed to be improved. In the weeks preceding the inspection a child had watched inappropriate DVD material in a young person's bedroom. At the time of inspection this incident had not yet been reviewed by the unit leader. There was no child protection notification. The social worker for the child had arranged to meet with the unit leader to discuss the incident however, the social worker for the young person was not aware of this meeting. The monitoring officer did not know about the incident.

Another safety concern was that two young people had been attacked and bitten by a local dog. These incidents had not been followed up with the Garda Siochana and the dog still had easy access to the young people. This was unacceptable and should be addressed immediately.

Staffing
Five full time staff members including two who were keyworkers had been transferred to another unit in August of this year. The young people were given four days notice of their departure. The general manager and line management for the centre told inspectors that the transfer had been a one off situation in response to over staffing of the unit. While the management of staff resources is necessary to ensure adequate staffing for all units, the manner of these transfers resulted in the loss of significant people in the children's lives without adequate preparation.

The centre does not have relief staff available to provide cover when staff are absent. When the centre required additional staffing they had to be sourced from the regular staff team of another centre. Inspectors recommend that the HSE area should source a stable relief panel for the centre.

Inspectors also query the practice of having two waking staff as standard. While the use of waking night staff was appropriate in this service at the time of inspection due to the specific behaviour of one young person it should be continuously reviewed to merit its continued use. The practice of having night staff is unusual in a community children's centre and generally should only occur in response to specific risks associated with a young person or a service.

Supervision
Staff members did not have regular supervision sessions. Two staff members had received one supervision session in the past year. Other staff members had not received supervision in over a year. The line manager supervised the unit leader on a monthly basis. The unit leader had responsibility to supervise nineteen staff members. It is not reasonable to expect one manager to supervise this number of staff. Child care leaders did not supervise child care workers. The responsibility for supervision by unit leaders and child care leaders was part of industrial relations discussions and the HSE told inspectors it was near resolution. At the time of inspection, child care leaders were paid more than child care workers without additional duties. The lack of supervision was unacceptable and should be addressed as a matter of urgency with interim arrangements agreed by the line management pending resolution of the IR issues.

Management
The management structure in the regional residential child care service was well resourced with two residential managers managing five centres between them. Each centre had its own unit leader. Inspectors noted the involvement of the unit leader in the direct care of the young people and in managing behaviour. Inspectors also commend the unit leader for encouraging new ways of working with the young people. The line management should review the management capacity in the centre with a view to ensuring appropriate leadership at times when the unit leader is not present. This centre had five of its fifteen posts at child care leader grade. Management should delegate responsibilities to child care leaders to ensure clear lines of responsibility and accountability in the day to day running of the centre.

Management of behaviour
The staff team had a difficult job in managing the challenging behaviour of some of the young people. There was a mix of skills with some staff members better at working with younger children than teenagers and vice versa. For instance, some staff members were not confident to travel alone with children in the house car while others had no difficulty in doing so.

Although the young people had been in the centre for a number of years the challenging behaviour and unhappiness of some of them was marked. The unit leader and staff had introduced a therapeutic approach based on psychodynamic principles and attachment theory two years previously in an attempt to improve the care in the centre.

The unit leader had provided presentations to the line management and staff team about the approach. Staff members had different views on the model in part due to a difficulty in integrating their own child care experience with the expectations of this model.

Although inspectors encourage innovative approaches to the care of young people which is child centred and appropriate, inspectors had concerns about the effectiveness of this method in the centre at this time due to;

- Unclear leadership in the absence of the unit leader
- Stability of the team
- The young people's understanding and consensus with the model
- Staff understanding and agreement with the model

Some staff members told inspectors that they were unclear about the approach and the underlying psychodynamic principles. All staff members acknowledged some value in the new approach when compared to previous practice in the centre and on the role of the unit leader in providing new ways of working with the young people. Inspectors were told that a staff team's resistance was a normal aspect of integrating the model. Inspectors were concerned that staff's lack of understanding or complaint about the method could be interpreted as resistance rather than a genuine and legitimate concern. This approach to staff concerns had serious implications for safeguarding and good team work in the centre. Managers are urged to give staff views greater weight when considering the impact of the therapeutic method.

There had been two physical restraints in the last year and sixteen absences without authority. There had been 30 physical assaults on staff members in the six months preceding the inspection. Six staff members had been off work for different periods of time due to occupational injury leave in the previous nine months. This level of aggression was detrimental to staff morale and the well-being of the young people partaking and witnessing such assaults. Social workers, staff members and a parent expressed concern about the perceived lack of authority in managing behaviour in the centre. While inspectors noted good examples of relationship based child care practice in managing behaviour, there were also incidences where staff members lacked authority to manage the young people. Some staff members and social workers also spoke of inconsistencies in practice when responding to young people's behaviour. Young people need to know that the adults caring for them have the appropriate authority and ability to keep them safe. A clear leadership structure, accountability through supervision, monitoring of practice by line management and clear expectations for behaviour agreed with the young people are all necessary to provide a safe environment.

Inspectors were told by staff members that there was no system of debriefing internal to the centre when a staff member was involved in a serious incident or when a staff member returned on shift after a period off work following an assault. The local HSE area had an employee assistance programme for debriefing and counselling external to the centre for staff members. There was no preparation of young people to meet the staff member they had injured. The HSE should ensure that guidance for centre managers on debriefing staff following assaults and preparing young people and staff to work together again is developed.

Inspectors identified a number of issues that had impacted on the morale of the staff team. These were: the lack of regular supervision, designated leadership when the manager was not present, staff's perception of poor support following injuries, the high levels of assaults on staff, uneven understanding and skills in the new therapeutic approach and the level of on site support from line management. Staff members told inspectors that staff morale varied significantly at times in the centre.

Inspectors were concerned about the management of behaviour through the use of 'transfers' and emergency discharges of young people to another residential centre. The experience for the young person is that they are moved in a crisis from their home without getting a chance to say goodbye to significant staff members, friends in the centre and in the community and may have to change schools as a result of the move.

In this centre a young person was sent to live in another residential centre four days before Christmas last year due to serious concerns about his safety and the safety of others. The monitoring officer expressed serious concerns about the manner in which this transferred occurred and was in the process of carrying out a review of the incident. The line management and the young person were unaware that this review was occurring.

There should be no emergency discharges from a long term residential centre. Any decision which will impact on a child's placement should only occur at a statutory care plan review meeting. If a young person is going through difficult times in the centre then more regular care plan reviews should occur to find ways to support the placement or organise a planned discharge if appropriate.

Communication and recording

Communication between professionals needed to improve. Social workers were unaware of significant plans for the renovation of the centre, which involved the young people moving premises for a short period of time while the works were completed. Two social workers had confidence the centre would notify them of significant events but another social worker had not been told of a cancellation of a family visit due to staffing difficulties nor of another significant incident. The HSE monitoring officer had identified poor communication with the young people's schools on a previous visit. Inspectors were told that this was being addressed through the appointment of a member of staff to liaise with the schools.

The process of recording of information also required improvement. Significant information about young people was inappropriately recorded at times in the communications book and incidents of physical restraint were not recorded on appropriate forms and were not signed. Inspectors heard several differing accounts of one incident and could not find the relevant record in the files. The purpose of each administrative record should be discussed with the staff team and records streamlined to reduce duplication and facilitate ease of access.

Register

The centre did not have a register in a secure format as information was stored in a loose leaf folder. It also did not contain information on the gender of the young people.

Practices that did not meet the required standard

The main areas which did not meet the standards were in relation to the provision of aftercare and accommodation.

The HSE area did not have aftercare workers or specific accommodation options for young people leaving care. A working group had been recently convened to address this issue and inspectors urge that a clear plan is devised as a matter of urgency.

The centre's accommodation was in poor physical condition. The young people told inspectors that because of the state of the building they were too embarrassed to bring their friends home to visit. The line manager and general manager had secured funding for the renovations and these were due to commence within the next month. Inspectors reiterate the view of the last SSI visit in September 2005 that these works should commence without delay.

2. Introduction

The Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Health Services Executive (HSE), Dublin Mid-Leinster region under section 69(2) of the Child Care Act 1991. The inspection fieldwork was carried out over a three day period on 2nd, 3rd, 4th October 2006 by Nuala Ward (Lead Inspector) and Kieran O' Connor (Support Inspector).

2.1 Methodology

The inspectors had access to the following documents during the inspection:

- The unit's statement of purpose and function
- The unit's policies and procedures
- The young people's care plans
- Questionnaires completed by social workers
- Census forms on management and staff
- Children's census forms
- The monitoring officer's reports
- The young people's care files
- Administrative records
- Health and Safety records

In the course of the inspection, inspectors interviewed:

1. The unit leader
2. Five members of the care staff
3. The four young people
4. The social workers for the young people
5. The monitoring officer
6. Three parents by phone
7. The general manager
8. The residential manager
9. The external consultant by phone

2.1 Acknowledgements

Inspectors wish to acknowledge the co-operation of the residential management, care staff and young people involved in this inspection.

2.2 Management structure

The centre was managed by a unit leader and line managed by the local residential manager who managed two residential centres. The line manager reported to the general manager who in turn reported to the local health manager.

2.4 Data on young people

Young Person	Age	Legal Status	Length of Placement	No. of previous placements
#1 (boy)	15	Care order	Six years	3
# 2 (girl)	16	Care order	Six years	2
#3 (girl)	15	Care order	Three years	8
#4 (boy)	11	Care order	Three years	2

3. Findings

3.1 Purpose and function

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

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

Recommendation

1. The HSE should ensure that the practice in the centre reflects its purpose and function to seek family placements for children under 12 years of age.

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 (including vetting)		√	
Supervision and support		√	
Training and development	√		
Administrative files	√		

Recommendations

2. The HSE should review the management capacity of the centre through the delegation of responsibilities to child care leaders.

3. The HSE should ensure that staff members receive regular supervision as a matter of priority.

4. The HSE should provide guidance to unit leaders in debriefing staff and young people following serious incidents.

5. The HSE should ensure there is a register in the centre which includes all the details required under the regulations and this information is stored in secure format.

6. The HSE should ensure staff members are aware of what constitutes a significant event and notify accordingly.

7. The HSE should operate a relief staff panel to reduce the practice of staff transfers.

8. The HSE should streamline the administrative records in the centre and ensure all staff members are aware of the purpose of each record.

3.3 Monitoring

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

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

3.4 Children's rights

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

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

Recommendations

9. The HSE should ensure that the monitoring officer's review of the transfer of one young person is completed as soon as possible.

10. The HSE should ensure that young people are consulted about any significant change to their placement or their care.

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	√		
Aftercare			√

Recommendations

11. The HSE should ensure that care plans are reviewed on a regular basis and the aims of the placement are reflected in the work of the social worker and the centre.

12. The HSE should ensure that social workers read records in the centre from time to time.

13. The HSE should ensure that there are sufficient aftercare facilities for young people leaving care.

14. The HSE should ensure that practice in maintaining and developing relationships with families is significantly improved in the centre.

15. The HSE should ensure that unplanned discharges of young people cease.

3.6 Care of young people

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

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

Recommendations

16. The HSE should ensure that there is an agreed approach to managing behaviour which is understood by all young people, staff and parents.

17. The HSE should ensure that all incidents of physical interventions are appropriately recorded, monitored, reviewed and notified to the relevant persons.

18. The HSE should ensure that the therapeutic model of care is appropriately monitored, reviewed and externally evaluated.

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		√	

Recommendations

19. The HSE should ensure that the National Guidelines for the Protection of Children as set out in Children First are understood and implemented by the residential staff and social workers in responding to and managing child protection incidents.

20. The HSE should ensure that the safeguarding policy includes a robust process for staff and other professionals to raises concerns about care in a centre

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		√	

Recommendation

21. The HSE should ensure that every effort is made to access an educational placement for one young person.

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	√		

Recommendation

22. The HSE should ensure that all immediate repairs and renovations are carried out in the centre without delay.

4. Summary of recommendations

1. The HSE should ensure that the practice in the centre reflects its purpose and function to seek family placements for children under 12 years of age.

2. The HSE should review the management capacity of the centre through the delegation of responsibilities to child care leaders.

3. The HSE should ensure that staff members receive regular supervision as a matter of priority.

4. The HSE should provide guidance to unit leaders in debriefing staff and young people following serious incidents.

5. The HSE should ensure there is a register in the centre which includes all the details required under the regulations and this information is stored in secure format.

6. The HSE should ensure staff members are aware of what constitutes a significant event and notify accordingly.

7. The HSE should operate a relief staff panel to reduce the practice of staff transfers

8. The HSE should streamline the administrative records in the centre and ensure all staff members are aware of the purpose of each record.

9. The HSE should ensure that the monitoring officer's review of the transfer of one young person is completed as soon as possible.

10. The HSE should ensure that young people are consulted about any significant change to their placement or their care.

11. The HSE should ensure that care plans are reviewed on a regular basis and the aims of the placement are reflected in the work of the social worker and the centre.

12. The HSE should ensure that social workers read records in the centre from time to time.

13. The HSE should ensure there are sufficient aftercare facilities for young people leaving care.

14. The HSE should ensure that practice in maintaining and developing relationships with families is significantly improved in the centre.

15. The HSE should ensure that unplanned discharges of young people cease.

16. The HSE should ensure that there is an agreed approach to managing behaviour which is understood by all young people, staff and parents.

17. The HSE should ensure that all incidents of physical interventions are appropriately recorded, monitored, reviewed and notified to the relevant persons.

18. The HSE should ensure that the therapeutic model of care is appropriately monitored, reviewed and externally evaluated.

19. The HSE should ensure that the National Guidelines for the Protection of Children as set out in Children First are understood and implemented by the residential staff and social workers in responding to and managing child protection incidents.

20. The HSE should ensure that the safeguarding policy includes a robust process for staff and professionals to raises concerns about care practices in a centre

21. The HSE should ensure that every effort is made to access an educational placement for one young person.

22. The HSE should ensure that all immediate repairs and renovations are carried out in the centre without delay.