A CHILDREN'S RESIDENTIAL CENTRE IN THE DUBLIN SOUTH CITY COMMUNITY CARE AREA OF THE HSE SOUTH WEST

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1 Executive summary

The Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in the Dublin South City Community Care Area of the Health Services Executive South Western Area (HSESWA) in December 2005.

The residential centre was initially established at this location in 1998 to care for a sibling group moving out of a larger residential establishment. The centre now provided long term care to adolescent boys and girls. In September 2004 a proposal was made to change the purpose and function to care for adolescent girls as part of a regional HSESWA residential change project involving all children's residential centres in their area. Inspectors were informed by senior managers that the residential change project was suspended at the time of inspection. The centre management and staff team had no knowledge of the time frame for the propose change.

There were two young people aged fifteen and sixteen years of age living in the centre at the time of inspection. Two young people had been discharged in the previous twelve months. One was detained to a special care unit through a court order and the other young person moved to a different centre as part of their placement plan.

The line management structure for residential services in the HSESWA was also changing with the recruitment of a new post of residential services co-ordinator. The expectation was that this person will be in post in the first quarter of 2006 and the Inspectorate acknowledge this as significant and trust it will result in higher standards of care.

The staff team had undergone a period of instability due to changes in management and this had resulted in some poor management and care practices. A new manager appointed in August 2005 had begun to introduce necessary changes in practice. Inspectors noted some staff members had difficulty accepting the status of the new manager, and work on this issue was ongoing. There was also evidence of conflict between staff members which was impacting on team cohesiveness and communication. This was being addressed by the centre manager and line manager.

The centre had an established practice of triple cover which was introduced some years previously in response to a different group of young people. It became endorsed as standard practice and was not subsequently reviewed in terms of continued appropriateness and cost effectiveness. It created an additional reliance on agency staff members and impacted on care practice. The inspectors recommend that the level of staffing in a centre is appropriate to the needs and risks associated with the young people.

The standard of daily record keeping was poor. At times, emotive and subjective language was used for recording incidents. Information was either not recorded or recorded indiscriminately in logs and files.

The centre had an experienced and stable staff group which contributed to consistency in the care of the young people. Members of the staff team spoke warmly about the young people. Several members of the staff team, the children, social workers, parents and foster parent all spoke highly of each other and there were good standards of inter-disciplinary communication. Inspectors observed warm relationships between young people and staff. Practice in relation to health and education was good.

The monitoring officer visited the centre on several occasions in 2005 and was in regular phone contact with the centre manager. Her role was considered supportive by members of the staff team. At the time of the inspection senior management were clarifying the role of the monitoring officer. Inspectors considered this necessary and also recommend a protocol for responding to recommendations following a monitoring visit should be devised.

Practice needed to improve in record keeping, children's meetings, supervision of staff members and the quality of placement plans. The deficits in these areas made it difficult to ascertain how the rights of the young people were meaningfully incorporated into the ethos of the centre. While knowledge about children's rights was generally good, how this was translated into practice needed to be improved. The inspectors noted that a number of these issues were beginning to be resolved by the centre manager with the staff team.

The statutory planning for aftercare was inadequate in meeting the needs of one young person who was sixteen years of age. The social worker informed inspectors that this was now being addressed through the care planning review process. The centre manager and staff team recognised the need to develop their practice in preparing young people for leaving care.

There was a good standard of contact with families in partnership with the social work department.

The standard on accommodation was not met. The centre was not in good structural repair and it was not decorated or maintained to a sufficient standard or one that created a pleasant living environment. The quality of the centre for a long term home for young people was unacceptable and the level of hygiene was poor.

The centre had previously been inspected in 2001. Out of the 23 recommendations of the last inspection, 11 had not been implemented, five only partially and information was not available to ascertain the status of two.

2. Introduction

2.1 Methodology

Interviews were held with the acting centre manager and five social care workers, the social worker for one young person and the social work team leader for the other young person, the line manager for the centre and the HSE's monitoring officer. Telephone interviews were held with the foster parent and birth parent of one young person. Of the two young people registered in the centre one young person was interviewed during the inspection visit and a telephone interview was held with the second young person. Care and administrative records were also examined as part of the inspection process. Inspectors spent time observing practice in the centre.

2.2 Acknowledgements

Inspectors wish to acknowledge the assistance provided to them by the manager and staff team and also the cooperation of the young people, parents, foster parent, social workers and all those who contributed to this inspection.

3. Setting the scene:

3.1 Background

This residential centre was originally set up to care for a group of siblings who had previously lived in a larger residential establishment. At the time of inspection it provided long term care to adolescent boys and girls. It is line managed by the Dublin South City Community Care Area. This centre had been previously inspected in 2001 and the inspection report is available on the SSI website as report number 28.

At the time of inspection a plan for the reconfiguration of residential services in the South Western Area was in the final stages of preparation. The aim of this 'residential change project' was to make the service more responsive to the range of needs of the young people entering it by maximising the use of existing resources.

3.2 Data on young people

Young person	Age	Legal Status	Length of time in centre
#1	16	Fit persons order	17 months
#2	15	Voluntary Order	3 years

At the time of inspection there were two young people living in the centre on shared care arrangements. One young person was accommodated in an educational facility during the week and returned to the centre at weekends. The other young person stayed in the centre during the week and spent most weekends with foster carers. Therefore, the staff team had the care of only one young person the majority of the week.

4. Standards: the findings

4.1 Statement of purpose and function

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

There was a generic statement of purpose and function with accompanying policies developed by the residential managers in Dublin South City Community Care Area for application in all of the local residential centres. The statement of purpose and function was non-specific and could be related to any type of residential centre. It stated that the duration of the placement would be determined on the needs of the child but all centres would provide medium to long term care; that the capacity of the centre would be determined by the size of the accommodation; and that the age of the young people would be determined by the age profile of the current residents and the prospective child to be admitted taking into account the best interests of all children.

The current purpose of this centre, according to the centre manager and staff team was to provide long term care to adolescent boys and girls. In September 2004 the centre management and staff members were told as part of the regional residential change management programme that the purpose and function of the centre would change to accommodate teenage girls on a long term basis. Neither the centre management not the staff team had a clear understanding of the time frame in which this change would occur.

A new statement of purpose and function should be agreed for this centre. It should outline the gender, age range and the type of care provided. This should give a clear focus for the development of appropriate policies and practices. Once this has been agreed the general manager, principal social worker and centre manager should decide how this plan will be communicated to the children, parents, staff members and any other significant persons.

This information is available in a child friendly format for the young people. It should be noted that the need to resolve the purpose and function of this centre was originally highlighted following the previous inspection in 2001.

Recommendation

1. **The Local Health Officer (LHO) manager with responsibility for child care should agree the purpose and function of the centre. A suitable process of informing the children, parents and staff members should be developed and implemented by the local general manager, the principal social worker and centre manager.**

4.2 Management and care staffing

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

4.2.1 Management

The centre was managed by an acting centre manager, who was employed on a permanent basis by the HSE South Western Area as a child care leader. His line manager was the principal social worker for the area who in turn reported to the general manager.

The impracticality of a principal social worker having a line management responsibility for residential centres has been highlighted through previous inspection reports. Inspectors were informed a new post of residential services co-ordinator for the HSE SWA was in the process of recruitment and it is hoped this will impact on developing higher standards. Inspectors acknowledge the development of this post as significant.

The centre has undergone a significant change in management in recent months. The previous centre manager was managing two centres for a phase prior to leaving in April 2005. Following this departure a child care worker acted up as centre manager until early August 2005 and understandably the standard of management was not met during this period. The current manager has introduced some appropriate and necessary changes in practice and these have had a positive impact on the operational structure of the centre. This change process required considerable readjustments involving some degree of team conflict. These issues impacted on staff cohesiveness and communication. There was some evidence of bullying within the team. This matter in conjunction with team communication difficulties was being reviewed by line management.

Good management of children's residential care indicates that the manager should inform and consult with the team on matters of child care practice. However, ultimate responsibility and accountability lie with the manager and, as such, he/she is directly responsible for all childcare practice, staff rotas and the use of agency staff.

Recommendations

2. **The centre manager should ensure all staff members enjoy appropriate working conditions in keeping with employment legislation.**

3. **The general manager and principal social worker should provide clarification about the role and responsibility of the centre manager to the staff team.**

4.2.2 Care staffing

There were nine staff members in the centre filling eight posts, where one post was being job-shared. The staff team was stable with many staff members working together for several years. Five of the staff team were employed on a temporary basis, and five including the manager, were permanent employees. Four had a professional qualification in social care and one staff member had a qualification in a relevant area. Two staff members were attending social care courses at the time of inspection.

The vetting of staff members was poor. There was no evidence of three written references on file for any staff member. There were no Garda clearances available for five staff members and only one staff member had received this clearance prior to starting work in the centre. The centre manager had recently applied for updated Garda clearances for all of the staff team and was awaiting the relevant documents.

The health service executive has a responsibility to ensure that they are satisfied about the suitability of the adults caring for their young people. Written evidence of the vetting of all staff members including agency staff should be sourced by the centre manager and this information maintained on the premises.

There was regular use of agency staff in the centre. Ten agency staff members were used to cover 20 shifts in the last month before the inspection. Although the centre was considered to be at full staffing capacity issues such as sick leave, annual leave, two staff members attending college, poor management of time of in lieu and no relief workers had resulted in a reliance on agency staff members. Furthermore the centre had an established practice of having three staff on duty which created an additional dependence on agency staff. As highlighted in previous inspection reports the use of transient temporary agency staff should be minimised and where possible eliminated in residential centres.

This centre had three staff members providing cover as standard practice yet provided care for only one young person the majority of the time. The centre manager was attempting to reduce this use of three staff and should continue to do so. This issue is further discussed under standard 4.7.1.

There was no external overview of the level of staffing in the centre. The HSE SWA should ensure their system of staff returns is a central process to monitor the use of agency staff to ensure it is appropriate to the needs of the centre and is cost effective.

There were evidence on the staff team of serious deficits in communication, and confidence in challenging care practice. One means of addressing this is ensuring that all staff members attend team meetings. Recent records in the centre reflected only sporadic attendance. Team meetings were highlighted as difficult due to poor conflict resolution and this issue should be addressed by the centre manager in partnership with the staff team.

Inspectors were concerned about the negative impact of communication difficulties, conflict avoidance, and bullying on general team cohesiveness and resilience especially if this team were to come under stress. The previous recommendations 1 & 3 are repeated here.

Although the centre manager is the person in charge of the centre, the staff team should also be empowered to develop confidence in their professional judgement. A balance should be struck between the accountability of the management and the need for the staff team to have confidence in their manager and in their own role.

Recommendations

4. **The principal social worker and centre manager should decrease the use of agency staff in the centre.**

5. **The centre manager should ensure that evidence of the vetting of all staff members including agency staff are available in the centre to ensure that it has been completed.**

6. **The HSE SWA should ensure their system of staff returns is a central process so that the use of agency staff is monitored to ensure its use is appropriate to the needs of the centre and is cost effective**.

4.2.3 Supervision and support

This standard had not been met. Some staff members stated they had not received any formal supervision since they started in the centre. Informal support was available from colleagues and the centre manager. There were no supervision records. The centre manager had devised a timetable for monthly supervision session commencing January 2006 and the expectation is that all staff member shall engage in this process as part of their duties as child care workers. He had also devised draft supervision forms to give structure to the process. Formal supervision is an essential aspect of residential care as it is a means of support to staff as well as a forum to raise any professional development issues. The lack of supervision in this centre is likely to have contributed to the blurring of professional roles and responsibilities and was highlighted as a deficit in the previous 2001 inspection report.

The centre manager received monthly supervision from the principal social worker for the area and also received peer support through regular managers meeting. It is important that the centre manager is supported during the centre's transition phase to allow him establish the expectations of his role and clarify any outstanding issues with the staff team.

4.2.4 Training and development

All of the HSE staff members had completed the relevant training in Therapeutic Crisis Intervention including the refresher training. Some of staff members attended a briefing session on Children First several months ago and Personal Development Training several years ago. The centre would benefit from a training needs analysis to prioritise the needs of the staff team such as training in record keeping and the Freedom of Information legislation. The HSESWA was also supporting two staff members to attend college. This was commendable.

Recommendations

7. **The centre manager should ensure that all staff members receive regular and formal supervision as a matter of priority.**

8. **The centre manager should undertake a training needs analysis of the staff team.**

4.2.5 Administrative files

The administrative files were poorly maintained with numerous different records used for daily information. These included a daily observation book on each child, an appointments

book, a diary, a communication book, a telephone message book, two time of in lieu (Toil) books and case files. At times records were not signed by relevant staff members. Information was recorded inconsistently and indiscriminately across various records. Subjective and emotive language was used to describe events. There was a lack of a professional approach to record keeping and paperwork.

There was evidence that numerous records were not maintained consistently. There were only two records of children's meetings in one year, the last serious incident and maintenance request was recorded in early 2004 and no records of sanctions was kept over a three year period. This is unacceptable.

There was a lack of understanding of the purpose of record keeping and the legal and statutory requirements for their existence. There was evidence that the current centre manager is monitoring current records, and has a clear understanding about the shortfalls in the current arrangements. Staff members should be trained in record keeping and understand the importance of maintaining accurate and objective records as well as have an understanding of the purpose of each administrative record.

Recommendation

9. The centre manger should ensure there is a clear system of recording and all staff members understand the purpose of each record and the associated legislative and statutory requirements.

4.2.6 Notification of significant events

The social workers stated they were regularly notified of significant events by the staff members and had confidence that the staff team would inform them of any incidents. There was no record maintained of who was notified of incidents other than those relating to absences without authority. The monitoring officer stated she did not believe that she was notified of all significant events as required under the regulations and the National Standards for Children's Residential Centres.

Recommendation

10. The centre manager should devise a system for the recording of the notification of significant events including the requirement to notify the monitoring officer.

4.2.7 Register

The centre had an up to date register which included the relevant headings as required under the regulations. However not all sections were completed such as full details of parents' addresses and contact details.

Recommendation

11. The centre manager should include all outstanding information in the register.

4.3 Monitoring

The Health Board, for the purpose 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.

The monitoring officer had most recently visited the centre in September 2005. She was in regular phone contact with the manager and had a good insight into the care practice and other dynamics in the centre. The monitoring officer was not confident that the centre notified her of all significant events and this was an ongoing issue for all centres in HSESWA.

The monitoring officer stated she had previously made recommendations to the line management about this centre albeit not in writing. In interview the line manager stated he had not received any written recommendations from the monitoring officer and could not clarify what recommendations had been made verbally.

This highlights a need for a protocol on reporting structures following a monitoring visit. This should include how monitoring recommendations are presented; who has responsibility for their implementation; and how outstanding issues are acted upon. Once put in place this internal process should ensure senior managers are made aware of failures under legislation and standards.

Recommendation

12. The LHO manager with regional responsibility for child care should ensure a protocol is in place for recommendations made by the monitoring officer, including reporting and implementation.

4.4 Children's rights

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.

The young people had a good understanding of their rights including their right to be respected, their right to access files and how to make a complaint. The young person's versions of the National Standards for Children's Residential Care were available to them.

4.4.1 Access to information

Although both the young people and staff members were clear about the rights of the young people to read their care files how this was translated into practice was questionable. The standard of recording information was poor and there was no evidence that young people had ever read their files. Some staff members were unclear about the status of third party reports, or how they could ensure the confidentiality of other persons mentioned in a report.

The issue regarding the standard of recording has been discussed under section 4.2.5.

Recommendation

13. The centre manager should ensure that the care files are organised in an appropriate manner to facilitate ease of access by the young people.

4.4.2 Consultation

There was that evidence young people were consulted about their views prior to case reviews, and their requests were listened to in a meaningful manner. The young people also felt they could raise concerns with staff members and that their concerns would be listened to. There was evidence that one child had been invited to a consultative day organised by the HSE SWA the previous year.

However, how the rights of young people were translated into centre practice required further review by the staff team. There was no evidence of regular children's meetings over a period of a year or any other formal means of seeking the views of the young people. There were no records of key working sessions.

There was evidence that the young people had recently complained about the décor of the house and had requested that it be made more homely by using photographs and other domestic touches. While there were some photographs on display, substantial further commitment is required to create a homely and modern living space. The young people's bedrooms in particular require attention and this is further discussed under Standard 4.10.1.

Recommendation

14. The centre manager and staff team should improve how they actively seek the young people's views.

4.4.3 Complaints

The generic complaints policy in the centre stated that the child's social worker and centre manager are informed of any complaints made by the child. The written procedure stated some of best practice principles derived from the National Standards of Children's Residential Centres such as ensuring that complaints are resolved satisfactorily and as soon as possible and also details the method of recording. A complaints register with the appropriate headings for recording was recently introduced by the centre manager although it did not contain any documented complaints made by the young people. However in examination of the young people's meeting minutes the young people had previously complained about the house décor and one young person had complained about the proposed change of purpose. There was no evidence of how they were resolved or subsequently recorded.

The young people said they were confident that staff members would respond to their concerns and get issues resolved locally.

Recommendation

15. The centre manager should ensure any outstanding complaints are resolved.

4.5 Planning for young people and young people

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.

4.5.1 Suitable placement and admissions

Both of the current young people were considered by their social workers to be appropriately placed.

There were two other young people previously placed in the centre during the 12 months prior the inspection. One young person's placement broke down within four months. This placement should be reviewed in order to identify the contributing factors which could provide learning for the future. One young person resided in the centre for a planned three months despite the purpose and function being for long term placements. The recommendation under standard 4.1.1. applies.

Decisions regarding admissions previously lay with the principal social worker following consultation with the centre manager. However, the HSE SWA has recently introduced an Admissions Committee in October 2005, which include representatives from both social work and residential care disciplines. This group was in relatively early formative stages and it is planned that referrals will be made through a group decision process. There was evidence of a good admission process being planned for a young person with their new keyworker visiting them in their current placement and devising a transition plan. There was no policy governing admission although this deficit should be addressed by the current overall policy development in progress in the area.

4.5.2 Statutory care plans and care plan reviews

Both of the young people had care plans on file. One plan did not accurately reflect recent changes in the young person's plan for their immediate future.

Both plans included significant details about access arrangements and reflected a family centred approach which is commendable. It should be noted that the action plans detailed as part of any care plan review should include detail of the responsibilities for these actions and a time frame in which they are to occur. Without there is risk that the care plan could become an administrative tool rather than a mechanism to provide meaningful structure for a child in care. This issue was highlighted in the previous inspection report which stated that 'allowing a plan to be open-ended can result in a child drifting in care'. This issue remains unresolved despite reassurances given during the inspection in 2001 that this issue would be addressed by the social work department.

Statutory reviews did not happen as frequent as required under the legislation. Both the young people and family members attend review meetings. There was also evidence of preparation work by the keyworker prior to such meetings to ensure the young person was helped to understand and contribute meaningfully to the process.

At the time of the planned change in the purpose and function, the care plan for one young person changed from long term residential care to foster care with the carers who fostered him

on a part time basis. Inspectors urge the HSE SWA to review the care plans of all children in long term residential care to see if alternative placements (foster care/return home/adoption) are a possibility.

One significant deficit was the lack of reference to planning for leaving care in the care plans. This was of particular relevance to one young person who was 16 years of age. Social workers have a regulatory responsibility as authors of care plans to ensure that two years prior to a young person reaching the legal leaving age of care, the care plan will outline detailed support and preparation available to them. This issue is further discussed under section 4.5.6.

Recommendations

16. **The social workers should ensure that care plans include detailed and focused action plans which set target dates for the achievement of goals.**

17. **The social workers should ensure that care plans are subject to regular review within the time frames required under legislation.**

18. **The social workers should ensure that leaving and aftercare plans are incorporated into the care plans when a young person is over sixteen years of age.**

4.5.3 Contact with families

The contact with families was well managed between the social work department and the staff team and visits to the centre by family members were actively encouraged. Any issues about access and transport arrangements were facilitated by the staff team in partnership with the social work department. The social workers had a key role in ensuring access occurred and there was evidence of a child centred approach whereby the views of the young people were central to this process. All significant family members were invited to attend review meetings, one parent had attended a meal in the centre and parents had significant confidence in the staff team. Access for one child was arranged outside of the centre according to their wishes. Family members told inspectors that they would like additional phone contact and further support in facilitating travel to the centre to visit the young people.

The social work department had a central role in managing and arranging access. While this family orientated approach by the social work department was commendable, the senior management in HSESWA should consider the effectiveness of allocating this work to a second access worker in the area to address time management issues.

4.5.4 Social work role

Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to any aspect of their care.

The young people spoke highly of their social workers. There was evidence of a good standard of interdisciplinary communication and of working in partnership for the well being of the children. The social workers were in regular contact through visits and phone contact with the staff team at a level appropriate to the young people's needs. The social workers had not read the files in the centre although they were aware of their obligation to do so from time to time as an additional safeguarding practice.

Recommendation

19. Social workers should read the case files in the centre on a regular basis.

Emotional and specialist support

The staff team and social workers had actively pursued successfully specialist services for the young people to order to meet their emotional, medical and educational needs. The staff team had a good insight into how one young person's behaviour was symptomatic of future changes and responded accordingly. The staff team's approach to managing behaviour was age appropriate and child centred.

4.5.6 Preparation for leaving care and aftercare support

This standard had not been met although this deficit has already been recognised by the centre manager and staff team. While a detailed transition plan had been prepared for one young person as they moved to another placement there was no aftercare plan for another young person. This should be addressed as a matter of urgency as the young person is due to leave care in the next year. A statutory review meeting planned within the next month is aiming to address this issue. This revised care plan should inform the subsequent placement plan, including the detail of the programme for preparing the young person to live independently.

Although the young people were encouraged to undertake laundry and other chores the management and staff team should devise a clear ethos of practice in relation to preparing young people for leaving care and developing skills for independent living. This should include a process of assessing skills and identifying areas requiring additional support for aftercare including suitable accommodation, financial assistance and available employment or educational opportunities.

Recommendations

20. The centre manager and staff team should prepare young people for leaving care.

21. The Local Health Office Manager with responsibility for child care should develop a policy on leaving care and after care support.

4.5.7 Discharges

Two young people were recently discharged from the centre. One was discharged in a planned manner as part of the placement plan. The other young person was referred to special care due to concerns about risk associated with unauthorised absences. There is a lack of clarity regarding the process for managing disagreement in relation to discharging young people although there is an expectation that the recently formed admissions group will have a monitoring role in this area.

Recommendation

22. The Local Health Office Manager with responsibility for child care should ensure there is a policy on the discharge of young people.

4.5.8 Children's care records

The care files were well maintained and included the majority of the information required. A birth certificate was missing for one young person and a summary page would be a useful addition. As discussed under the previous standard 4.4.1., the organisation of the case files should be reviewed to ensure their suitability in facilitating ease of access by the young people.

There were no records of keyworking sessions and placement plans were based on short term fortnightly plans which were reviewed weekly at the team meetings. Records were maintained of these weekly reviews albeit in a separate file.

4.6 Care of young people

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

4.6.1 Individual care in group living

The young people were happy with their care in the centre and spoke highly of the staff team and management. The young people were cared for in a manner which was attentive to their individual needs. The inspectors observed warm, child centred and age appropriate interactions between staff members and one young person. The staff team are commended for facilitating young people's involvement in the local community and the social support developed with peers. The young people's birthdays were marked according to their wishes and friends are encouraged to visit. The interests of each young person were actively encouraged and regular visits made to local facilities. Staff members went on outings with the young people chose there own clothes.

4.6.2 Provision of food and cooking facilities

There was a good choice of food and both young people expressed satisfaction about the quality of food and share meals with staff members on a regular basis.

4.6.3 Race, culture, religion, gender and disability

This standard had been met as the young people were encouraged to attend religious ceremonies and their wishes respected. The young people were encouraged to reach their full potential through accessing appropriate resources to meet their needs in education and also through encouraging their individual interests.

4.6.3 Managing behaviour

Several staff members told inspectors that a negotiating approach of managing behaviour was the foremost method of responding to challenging behaviour. The inspectorate observed this in practice with one young person. The policy on managing behaviour emphasised that consequences should be underpinned by the young people learning from the episode and gave details of appropriate and inappropriate sanctions.

It was difficult to assess how this policy translated into practice as there were no consistent records of sanctions or serious incidents. The most recent records from 2005 demonstrated a reliance on grounding as a consequence. From information scattered in other records it appeared that at times the behaviour management approach was inappropriate and the use of sanctions were not reviewed. The current manager is monitoring the records and should review the use of sanctions on a regular basis as a means of assessing their value in addressing specific behaviour. The de-escalation skills from TCI model was also cited as useful interventions in responding to challenging behaviour.

4.6.4 Restraint

Physical restraint had been used very rarely in the centre with no episodes of restraint in the past year. There was a good understanding of the HSESWA expectations regarding the use of physical restraint and all the HSE staff members had completed the full and refresher training in the TCI model. There was a good understanding about the appropriate use of restraint.

An issue of concern related to the appropriateness of the use of restraint with the current young people. Staff members cited its use as inappropriate due to the physical size of the young people and only one staff member referred to the pre-existing medical conditions of both young people as a contra-indictor for the use of restraint. The implementation of Individual Crisis Management Plans (ICMP) for the young people is the TCI method to highlight appropriate and inappropriate methods of intervention with young people. The ICMP should be informed by experience from previous placements and reviewed on a regular basis.

Recommendation

23. The centre manager should ensure that all staff members have knowledge of the Individual Crisis Management Plans for the young people.

4.6.5 Absence without authority

The centre had 45 absences in the last year. Thirty nine of these absences were by one young person who was subsequently detained by the courts in a Special Care Unit due to risks associated with this behaviour. The centre had a detailed notification process once a child is considered absent and at risk. This includes notification of the description of the child to the social worker, LHO Manager, child care manager, principal social worker, social worker, local Garda stations, the Crisis Intervention Service (CIS) and to local hospitals. The social workers are satisfied that there are contacted if a young person is absent. It is appropriate when a young person is considered at risk that such a formal process is initiated but the centre manager should ensure that individual risk and professional judgement dictates practice for each young person.

Absences from failure to comply with curfew times were the most common type of absences. Staff made all efforts to contact the young people to try to locate and encourage them to return.

The centre manager has discussed with line management the viability of the current system based on queries from the Crisis Intervention Service regarding the function of notification of absences to their service. The HSE SWA should devise an appropriate policy based on individual risk assessment which details the expectations of the relevant parties following

notification. It should also focus on developing good professional relationships with local Garda Siochana stations. The recently published SSI guidelines on best practice in this area of care would be a useful source of information.

Recommendation

24. The LHO manager with regional responsibility for child care should review the policy for notifying unauthorised absences for young people to ensure it is appropriate and reflects the individual needs of the young people.

4.7 Safeguarding and child protection

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.

The staff members had good insight into safeguarding practice such as ensuring colleagues know of each others' whereabouts, the need for appropriate professional boundaries and respect for the rights of children.

Having three staff on duty at a time to ensure that staff members are not left on their own in the centre with a young person was cited by several staff members as one of the most essential safeguarding practices. This meant that when a staff member accompanied a child to an appointment, two members of staff were required to remain in the centre with the second young person. Several staff members erroneously believed that this level of cover was required by legislation. It was introduced some years previously in response to a different group of young people and subsequently became endorsed as standard practice. This practice is inappropriate and should no longer occur as part of the standard regime in the centre. The level of staffing in a centre should be appropriate to the needs and risk associated with the young people. The centre manager had begun to address this issue. The Inspectors also recommend that the current designation of staff bedrooms on the opposite sides of the house to children's bedrooms should be reviewed to maximise safeguarding.

Recommendations

25. The use of triple staffing cover should be stopped.

26. The centre manager should review the current designation of staff and children's bedrooms to maximise safeguarding.

4.7.2 Child protection

There are systems in place in the centre to protect young people from abuse. Care staff are aware of and implement practices which are designed to protect young people in care.

There was a good understanding of child protection. There were no outstanding child protection assessments. The policy on child protection required revision to include details of the process of assessment, reporting and recording procedures and managing disclosures and allegations. This was previously recommended as part of the 2001 inspection and a new policy document is in the process of being drafted by the HSESW area.

The emphasis on child protection should focus on protecting young people from abuse, not protecting staff from allegations. Good child protection policies and safeguarding practices will have the secondary positive impact of ensuring staff members' practice is transparent and accountable.

Recommendation

27. The LHO regional manager for childcare should ensure that a comprehensive child protection policy is in place for this centre and all staff members understand its contents.

4.8 Education

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 education facilities.

The standard on education was well met and both of the young people were in full time secondary education. An educational plan was on file for one school which was reviewed on a regular basis in consultation with the young person. The staff team displayed an obvious commitment to maintaining young people at their school through encouragement and support to attend and regular contact with relevant schools. This is commendable.

One young person is moving to a new school closer to their new placement which is considered more appropriate to meeting their needs. This is being managed by the social work department and staff team.

4.9 Health

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

The health needs of the young people were well met. There was a medical assessment on file for both young people as well as records of their previous immunisations and hospital visits. There was evidence that the staff team were encouraging healthy eating and good oral hygiene with one young person and addressed the specific medical needs of another young person. A locked, well stocked medical cabinet was situated in the staff office. The young people could also visit a male or female local G.P. and both young people had a medical card in their own right.

4.10 Premises and safety

The premises are suitable for the residential care of 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 and 13 of the Child Care Regulations, 1995.

4.10.1 Accommodation

The centre was located in a semi-detached house in close proximity to shopping, schools and public transport. The house was spacious with five bedrooms, a large garden to the rear and a large open area to the front. It had two living areas; one general sitting room and a separate living area to the front of the house which contained a pool table.

The physical condition of the centre was poor with dated décor, rubbish in the garden, a broken washing line and a general unkempt appearance. The general hygiene and day to day house keeping was of a poor standard. There was dirt on the inside of the front window sill, large stacks of paper in the corner of the front living room, large sections of the wall paper in the hallway was badly marked, and there were paint stains on the glass panel on the front door. One staff member informed the inspectors that cleaning was completed daily, another staff member told inspectors it depended on what staff member was on duty.

There was evidence of institutionalisation whereby the children's bedrooms had linoleum covering the floor while staff bedrooms had carpet and labels in the hot-press marking a specific area for staff clothing. One young person's bedroom had sections of chipboard as temporary wardrobe doors. Repainting the front living room and two of the young people's bedrooms had halted midway leaving sections unfinished.

Young people should have a sense of pride in their home and this should be lead by staff members showing care for the physical environment they share with the young people. The gardens should be free of rubbish, the broken washing line removed and general hygiene maintained to a high standard. One empty bedroom required cleaning and redecorating before another child moved in. Both young people had recently complained about the house being too old.

There was evidence that the centre manager has requested funding for new fittings and furnishings and this funding should be made available as soon as possible.

It is deplorable that this standard of accommodation is considered acceptable by the HSESWA for their young people living in this residential centre.

Recommendations

28. The staff team should ensure there is a good standard of hygiene in the house.

29. The general manager should allocate funding for this centre to be redecorated to an acceptable standard including carpeting the young people's bedrooms.

4.10.2 Maintenance and repairs

The most recent request for maintenance was dated November 2005. The centre manager informed the inspectors that the response of maintenance was adequate in comparison to his previous experiences. Nevertheless there were numerous maintenance issues through the house such as a broken washing line and the door bell and wardrobe door handles in the young people's rooms needing replacing.

30. The centre manager should ensure that all outstanding maintenance issues are completed in a timely fashion.

4.10.3 Safety (including fire safety)

The local fire officer informed the inspectors in writing that while the centre does not have a fire certificate 'Discussions are ongoing with Dublin Fire Services in relation to fire certification for Children's Residential units' and that this centre is being used 'in discussion cases in relation to fire certification of residential units'. He also included details of the works that have been carried out as follows; A L1 Type fire alarm has been fitted, emergency lighting, installation of fire fighting equipment and ongoing fire training for staff.

The last health and safety audit was completed in 2003. A copy of this report was not available in the centre. A new audit must be completed as soon as possible. The centre manager and staff team must ensure that any obvious safety hazards are managed appropriately such as repairing the trailing wires in the hallway.

There was a designated fire safety officer in the centre and fire equipment was checked on an annual basis. The fire alarm system had been recently checked in May 2005. The staff team had recently received training in fire safety. The most recent fire drill was in September 2005. There was no consistent record of regular drills occurring prior to this date.

The road worthiness of the mini-bus was highlighted as a concern due to ongoing maintenance issues and there was written evidence that the centre manager had requested funding for a new vehicle. The general manger for the area should review the need for a mini-bus as some young people in care find this potentially stigmatising.

Recommendations

31. The centre manager should continue to ensure that fire drills occur on a regular basis and are appropriately recorded.

32. A health and safety audit should be carried out in the centre as soon as possible and any safety hazards appropriately managed.

33. The general manger for the area should ensure that a less stigmatising and institutionalised vehicle is purchased for the young people which is road worthy and safe.

34. The general manager should ensure a fire certification is obtained for this centre as soon as possible.

5. Summary of Recommendations

1. **The Local Health Officer (LHO) manager with responsibility for child care should agree the purpose and function of the centre. A suitable process of informing the children, parents and staff members should be developed and implemented by the local general manager, the principal social worker and centre manager.**

2. **The centre manager should ensure all staff members enjoy appropriate working conditions in keeping with employment legislation.**

3. **The general manager and principal social worker should provide clarification about the role and responsibility of the centre manager to the staff team.**

4. **The principal social worker and centre manager should decrease the use of agency staff in the centre.**

5. **The centre manager should ensure that evidence of the vetting of all staff members including agency staff are available in the centre to ensure that it has been completed.**

6. **The HSE SWA should ensure their system of staff returns is a central process so that the use of agency staff is monitored and reviewed externally to ensure its use is appropriate to the needs of the centre and is cost effective**.

7. **The centre manager should ensure that all staff members receive regular and formal supervision as a matter of priority.**

8. **The centre manager should undertake a training needs analysis of the staff team.**

9. **The centre manger should ensure that the centre has a clear system of recording and all staff members understand the purpose of each record and the associated legislative and statutory requirements.**

10. **The centre manager should devise a system for the recording of the notification of significant events including the requirement to notify the monitoring officer.**

11. **The centre manager should include all outstanding information in the register**

12. **The LHO manager with regional responsibility for child care should ensure a protocol is in place for recommendations made by the monitoring officer, including reporting and implementation.**

13. **The centre manager should ensure that the files are organised in an appropriate manner to facilitate ease of access by the young people.**

14. **The centre manager and staff team should improve how they actively seek the young people's views.**

15. **The centre manager should ensure any outstanding complaints are resolved.**

16. **The social workers should ensure that care plans include detailed and focused action plans which set target dates for the achievement of goals.**

17. **The social workers should ensure that care plans are subject to regular review within the time frames required under legislation.**

18. **The social workers should ensure that leaving and aftercare plans are incorporated into the care plans when a young person is over sixteen years of age.**

19. **Social workers should read the case files in the centre on a regular basis.**

20. **The centre manager and staff team should prepare young people for leaving care.**

21. **The Local Health Office Manager with responsibility for child care should develop a policy on leaving care and after care support for the area.**

22. **The Local Health Office Manager with responsibility for child care should ensure there is a policy on the discharge of young people.**

23. **The centre manager should ensure multi-disciplinary Individual Crisis Management plans are developed and regularly reviewed as part of the implementation of the TCI model in the centre.**

24. **The LHO manager with regional responsibility for child care should review the policy for notifying unauthorised absences for young people to ensure it is appropriate and reflects the individual needs of the young people.**

25. **The use of triple staffing cover should be stopped.**

26. **The centre manager should review the current designation of staff and children's bedrooms to maximise safeguarding.**

27. **The LHO regional manager for childcare should ensure that a comprehensive child protection policy is in place for this centre and all staff members understand its contents.**

28. **The staff team should ensure there is a good standard of hygiene in the house.**

29. **The general manager should allocate funding for this centre to be redecorated to an acceptable standard including carpeting the young people bedrooms.**

30. **The centre manager should ensure that all outstanding maintenance issues are completed in a timely fashion.**

31. **The centre manager should continue to ensure that fire drills occur on a regular basis and are appropriately recorded.**

32. **A health and safety audit should be carried out in the centre as soon as possible and any safety hazards appropriately managed.**

33. **The general manger for the area should ensure that a less stigmatising and institutionalised vehicle is purchased for the young people which is road worthy and safe.**

34. **The general manager should ensure a fire certification is obtained for this centre as soon as possible.**