SOUTHERN HEALTH BOARD

NORTH LEE COMMUNITY CARE AREA

CHILDREN'S RESIDENTIAL CENTRE

INSPECTION REPORT

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1. Executive summary

This section contains a brief summary of the main findings and conclusions of the inspection of a children's residential centre (CRC) run by the North Lee Community Care Area (NLCCA) of the Southern Health Board (SHB), which took place on the 9th – 11th June 2004. Readers wanting a more detailed account should refer to the main sections of the report.

The centre was situated in a building that had been a children's home under the Mercy Child Care Services for several decades before transferring to the SHB in 2001. It provided care for up to ten boys and girls from the NLCCA. The range of care offered was medium term care, - described as between six months and two years, shared care, respite care, and outreach. The age range for admission was 12 to 15 years. At the time of the inspection there were six young people, four girls, one boy and one young man aged 19 in the centre. The building was described as unsuitable for its purpose by the majority of people interviewed by the inspectors. It was a large Victorian house in its own grounds, with institutional characteristics. Managers of the board acknowledged its unsuitability and said that they were determining ways to transfer the centre to more suitable premises.

There was a care staff team of twenty eight and seven ancillary staff. The care staff had considerable collective experience in residential child care. Eighteen of them had professional qualifications in child care. The group also had a range of other educational qualifications, including degrees and diplomas in nursing, social work, health administration, counselling, psychotherapy, youth and community work, and social studies. The centre was well managed, and in interviews with inspectors the staff were praised by professionals and parents and for the high standard of care they offered the young people. The majority of staff was fully vetted. However, there were omissions in five cases.

Inspectors found that relationships between the staff and young people were characterised by warmth, respect, commitment and a high standard of professionalism. Staff had a good awareness of safeguarding issues, and their practice reflected this. Young people told inspectors that the staff were kind, fair and impartial, and one parent described the service provided to the young people as 'brilliant'. The young people were consulted about decisions that affected their lives and were aware of how to make any complaints or discuss any worries with the staff. In the year prior to the inspection they made twenty eight complaints that were dealt with by staff through procedures that were prompt and responsive, and the young people were satisfied with the outcomes of most of them. They were included in discussions about their future, invited to reviews, and participated in regularly held residents' meetings. Those interviewed all said that they trusted their keyworkers, that the staff were caring, and that their privacy was respected. They could exercise choice about food, clothing, the décor of their bedrooms and holidays. Links with their families were strongly promoted and facilitated, and they were given opportunities to engage in a wide range of activities in the centre and in the local community. Within the centre there was a range of recreational rooms with games and computers. The centre had two vehicles to facilitate taking the young people to the city or to outings elsewhere.

Monitoring visits were in progress since January 2004. Since then the monitor had made a total of five visits. The monitor told inspectors that her recommendations were quickly acted on after each visit. She told inspectors that she found that the centre was well led and had a committed staff team for whom the young people were a priority.

Inspectors found that the standards for education and health were well met. They commend the centre staff for supporting the young people in their education. Communication between the staff and social workers was generally good. The frequency of social work visits to the unit for

some of the young people was within statutory requirements, but over the year prior to the inspection there had been significant gaps in the visits to two of them.

Four out of the six young people in the centre had written care plans. The plans for three of them had been prepared within the statutory timescales. Of these, two were of good quality while the other pre-dated the placement by several months and was incomplete. Practice in respect of reviews of care plans was variable. Inspectors found that regular reviews within statutory timescales had been held for three of the six young people in the centre. However, meetings had been held for the other three of them, even though they did not have care plans. The gaps between review meetings for two of the young people were 16 and 20 months. This is unacceptable, and inspectors have recommended that it should be remedied.

The young people had their own bedrooms. Girls had spacious rooms on the first landing of the main building, while the boys had theirs in an annex connected to the main house by a corridor/bridge. The centre had a comprehensive health and safety statement, and a recently conducted health and safety audit. Inspectors commend the board for the appointment of a fire and safety advisor with special responsibility for all the board's children's centres. Inspectors found that the staff had good safety procedures and safety awareness.

Inspectors found that the centre had shown admirable commitment to young people who had stayed at the centre beyond their 18th birthdays and were without arrangements for aftercare. This was done in the absence of a board-wide policy and service for the provision of aftercare. The centre had an outreach worker who provided a service for young people in transition to other SHB residential services, and liaised with families where communication with the young person had become difficult.

Young people and staff in the centre had access to the services of a senior clinical psychologist who was assigned to three residential children's centres in the NLCCA. Individual young people also had access to psychiatric services, and there was a good standard of partnership between the various professionals involved in their lives. For two of the most vulnerable young people there were core group meetings of all the key professionals held every four to six weeks.

Although inspectors have made a number of recommendations in order to bring aspects of the service in the centre to a level that will meet the requirements of the *National Standards for Children's Residential Centres,* the overall impression is of a centre well managed, professionally staffed, and well regarded by the professionals associated with it and, most importantly, by those for whom it provides a service. The managers and staff are highly commended for the quality of care they provide.

2 Introduction

The Social Services Inspectorate (SSI) carried out the inspection of the Children's Residential Centre (CRC) in the North Lee Community Care Area (NLCCA) of the Southern Health Board (SHB) under the *Childcare Act 1991, Section 69 (2)* which provides authority for the inspection of the social services functions of health boards, including children's residential centres.

The inspection took place on 9th – 11th June 2004. The lead inspector was Michael McNamara, and Andrew Fagan was support inspector.

2.1 Methodology

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

- The centre's statements of policies and procedures,
- The young people's care files,
- The young people's daily log books,
- All administrative recording systems,
- Questionnaires completed by parents, teachers, and social workers,
- Census forms on staff,
- Census forms on young people,
- Staff rotas,
- A sample of staff files,
- Health and safety audits for the centre,
- The centre's health and safety statement.

In the course of the inspection inspectors interviewed five of the young people living in the centre, the centre manager, and seven staff. Others interviewed included: two parents (one by telephone), the child care manager of NLCCA, the monitor, the senior clinical psychologist associated with the centre, a representative of the personnel department of the SHB, four social workers and an outreach worker. The lead inspector also interviewed the health and safety advisor by telephone.

2.2 Acknowledgements

Inspectors wish to thank the young people and staff for their assistance and hospitality, and to acknowledge the co-operation of the staff in the centre, health board managers and other professionals in this inspection.

3 Setting the scene: background, the centre and its population

3.1 Background

The centre was in an old house that had opened as a boys' home run by the Mercy Congregation in 1932. It became a centre for boys and girls, and in April 2001 the service was transferred to the SHB. At that time it had a capacity for 12 young people. Its purpose was to provide care for children who could not be cared for at home, up to the age of 18 years. It did not have a hard and fast rule about the upper age limit, and young people over 18 years could stay in the centre longer if they were continuing education, or for other reasons. Inspectors were told that at the time of the inspection the building was in the process of being handed over

to the SHB as part of the redress scheme. They were also told that the capacity of the centre was 10 young people. The building was described as unsuitable for its purpose by the majority of people interviewed by the inspectors. It was a Victorian house in its own grounds; and in keeping with its original size and purpose it had a labyrinth of rooms within a range of extensions, many of which were no longer in use.

At the time of the inspection, the centre's policies and procedures had been reviewed and updated over several years. Some were used in common with other SHB centres, and others were specific to the centre itself.

3.2 Data on Young People

There were six young people in the centre at the time of the inspection. Details of their legal status, length of placement and previous placements are shown in the table below.

Details of Young People in CRC – 9th June 2004

Young Person	*Age in Years*	*Legal Status*	*Type of Placement*	*Length of Time in CRC*	*Previous Placements*
Young Man	19	(*Originally a Care Order*)	Full Time Residential	8 years 2 months	None
Girl	15	Voluntary Agreement	Shared Care	6 years 11 months	Two Foster Care Placements
Girl	15	Court Order	Full Time Residential	11 months	Children's Residential Centre Special Care Unit
Boy	14	Care Order	Respite	3 years 11 months	Several Foster Care Placements
Girl	14	Care Order	Full Time Residential	1 year 11 months	Relative Care Foster Care
Girl	12	Care Order	Full Time Residential	5 months	Several Foster Care Placements

There was also one young person aged 16 years visiting the centre as part of his programme of introductory visits before full admission. Inspectors also interviewed a young woman aged over 21 years who was still receiving support from the centre staff. Before leaving its care she had been resident in the centre for 14 years. All the young people in the centre were from the North Lee Community Care Area.

4. Standards: the findings

4.1 Statement of purpose and function

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

The unit had a clear written statement of purpose and function that had been drawn up in December 2001. Staff interviewed by the inspectors understood well the purpose and function of the centre. It described the centre as an integral component of the SHB provision of Child and Family Support Services, providing a structured, caring and supportive environment for children who could not be cared for at home. It described the ethos of the centre as holistic, - aiming to enable children realise their intellectual, spiritual, emotional, social, cultural and physical potential. It also affirmed the principles of respect for the rights and individuality of children and partnership with other professionals and parents. The statement of purpose and function was supplemented by the centre's policies and procedures, which were comprehensive, clear and well considered. Inspectors were told that they have been under constant review. They are referred to, as appropriate, throughout the report.

The statement said that the centre offered medium-term care, and defined that as between six months and three years, for up to 10 young people, boys and girls. It also offered respite care, shared care, and outreach support. The stated age on admission was between 11 and 15 years. Inspectors found that most aspects of the statement reflected practice in the centre, but there had been changes in the service offered by the centre since it had been drafted originally. The age range of the young people resident in the centre at the time of the inspection was 12 to 19 years, and a young person about to be admitted was aged over 16. Two of the young people had been in the centre in excess of three years, and the staff were offering outreach to an ex-resident long after she had left care. The most recent admissions to the centre were of young people with significant levels of vulnerability who presented challenging behaviour, or whose educational needs were not being met. These were specified as criteria in a recent document outlining the centre's admission policy. Inspectors recommend that the statement and function be reviewed and up-dated in order to bring it into line with the board's policy of placing children under the age of 12 years in foster placements rather than in residential care, to make it a more accurate description of what the centre sets out to do, and to reflect the position and function of the centre in the board's current overall child care strategy.

Recommendation

1 The board should review the centre's statement of purpose and function.

4.2 Management and care staffing

The unit 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.

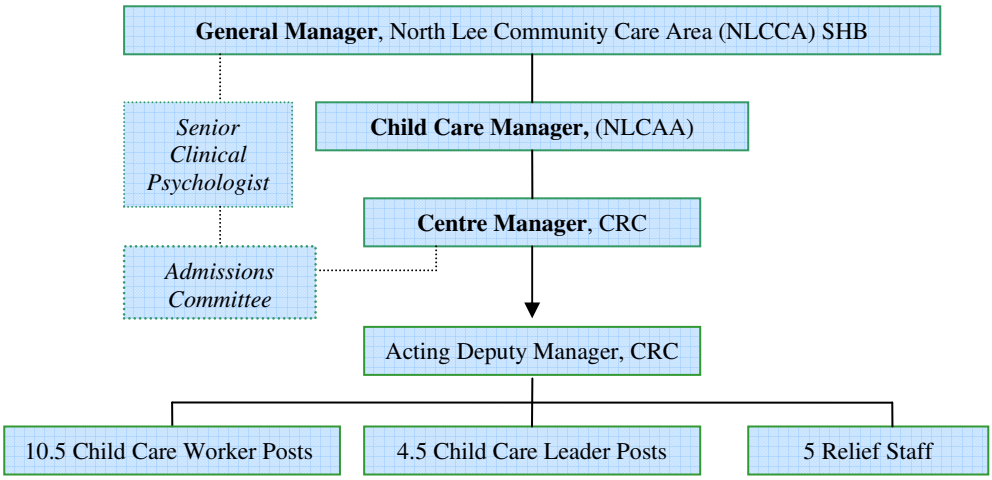
4.2.1 Management

The centre manager had qualifications in social care and nursing and had worked at the centre for nearly 14 years. She reported to the child care manager of NLCCA who has been given responsibility for all the children's residential provision run directly by the board. He in turn reported to the general manager of NLCCA. There was an acting deputy centre manager, and four and a half child care leader posts shared between six staff.

The centre had an admissions committee made up of the manager of the CRC and managers of two other SHB residential children's centres. It considered referrals, and occasionally discharges in terms of vacancies that might arise in the three centres. A principal social worker that was not directly involved in the provision of residential services chaired the committee's meetings. The senior clinical psychologist and a social worker also attended them.

The structure of the management of the CRC is shown in the chart below.

Management Structure of CRC – June 2004



Both the manager and the acting deputy manager shared on-call duties. They told inspectors that the staff used on-call appropriately. Supervision of staff was divided between them and the child care leaders. The child care leaders had responsibility for the organisation of shifts at weekends.

With effect from May 2004 a new post of regional co-ordinator of the SHB's residential services became operational. The objective of the re-organisation was to co-ordinate as many aspects of the residential service as possible, such as the admissions procedures, training, and policies and procedures, to promote a common culture and ethos, and to identify gaps in the service.

4.2.2 Register

The centre had a register. It was a large custom-made book that held details required by the *Childcare (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 21 (2).* It gave details of each instance of respite care. It did not record the gender of the young people or the address of the unit. Owing to the form of the register it would not have been possible to maintain an exact duplicate in administrative offices of the board, so a system was in place whereby monthly and quarterly returns were sent to the board's child care information officer. These had most of the information required by the regulations, but would not meet the standard fully.

Inspectors recommend that the register be modified to include all the details required by the regulations, and that a true replication of the information in the unit's register is maintained, albeit in an electronic format. They also advise the board to consider ways in which the information in the register on respite care could be rationalised.

Recommendation

2 The board should ensure that the unit's register includes all the details required by the regulations, and that a duplicate of the information it contains is kept in administrative offices of the health board as required by the standards.

4.2.3 Notification of significant events

The centre had a procedure for the notification of significant events. Parents and social workers confirmed to inspectors that they were routinely and promptly notified about significant events. Evidence of a prompt notification procedure was found in the care files. However, social workers told inspectors that the volume of information sent on each individual significant event was considerable, and occasionally it was difficult to determine the urgency of the report without reading the whole text. Inspectors were of the view that the reports could be streamlined, and there would be benefit in a system of headlining so that the recipient could assess the urgency of the report before reading the full text. Inspectors also advise that the staff in the centre come to an agreement with social workers and the centre's monitor about how events are to be reported.

4.2.4 Care staffing

At the time of the inspection the unit had 28 care staff including the manager and acting deputy manager in a total of 15 posts. Seven were in full time permanent posts, seven part time permanent, three full time temporary, six part time temporary and five relief. Seven staff worked a 39-hour week, three staff worked 35 hours per week, and three staff worked 32 hours, six for 24 hours, and the others for periods of 8 – 20 hours per week. Three of the full time temporary staff had been in post for over three years. Four and a half child care leaders' posts were shared between six staff, and 10.5 child care worker posts were shared between fifteen staff. Two of those posts were night staff. Waking night staff worked seven nights on and seven nights off. The centre had doubled the number of staff on waking nights in December 2003 after an assessment of risk. This was no longer the position at the time of the inspection. The staff team was not broken down into smaller shift teams, except at the weekends.

The centre also had seven ancillary staff comprising two clerical officers, three housekeepers, a cook and a maintenance man. Four were appointed before the centre transferred to the health board. All had received training in Children First, fire safety and manual handling.

Although it is understood that the centre's staffing arrangement came about primarily through its history, and to some extent it reflects the potential numbers of young people that the centre could take, inspectors were of the view that it was fragmented and had the disadvantage for the young people of presenting to them a wider range of carers than they would meet in any other residential setting, except a special care unit. Inspectors recommend that the staffing in the centre is reviewed by the board.

Recommendation

3 The board should review the arrangements for staffing in the centre.

The staff group comprised people with a considerable depth of experience in child care. The average age was 33 years and three months, with a range of 20 to 59 years. The average length of service in residential care was five years six months, and the average length of service in the centre was nearly four years ten months.

Full details of the staffing of the unit are shown in the table below.

Staffing of the CRC – 21st May 2004

	Staff	*Hours*	*Employment Status*	*Length of Service in* CENTRE	*Qualifications*
#1	Manager	35+	Full Time Permanent	13 years 10 m	National Diploma in Applied Social Studies in Social Care, Diploma in Hospital/Health Service Administration
#2	Acting Deputy Manager	35	Full Time Permanent	16 years 9 m	BA Applied Social Studies
#3	Childcare Leader	8	Part Time Permanent	12 years 10 m	BA Applied Social Studies
#4	Childcare Leader	24	Part Time Permanent	9 years 8 m	National Diploma in Applied Social Studies in Social Care
#5	Childcare Leader	39	Full Time Permanent	6 years 7 m	National Diploma in Applied Social Studies in Social Care
#6	Acting Ch Care Leader	32	Part Time Permanent	5 years 8 m	BA in Applied Social Studies in Counselling & Psychotherapy
#7	Acting Ch Care Leader	39	Full Time Permanent	3 years 9 m	BA Applied Social Studies
#8	Acting Ch Care Leader	39	Full Time Temporary	1year 2 m	Diploma in Social Work (Netherlands)
#9	Childcare Worker	39	Full Time Permanent	16 years 3 m	National Diploma in Childcare
#10	Childcare Worker	35	Full Time Permanent	6 years 10 m	No qualification
#11	Childcare Worker	39	Full Time Permanent	4 years 6 m	National Diploma in Applied Social Studies in Social Care
#12	Childcare Worker	39	Full Time Temporary	4 years 4 m	BA in Applied Social Studies in Social Care
#13	Childcare Worker	10	Part Time Permanent	3 years 8 m	National Diploma in Childcare
#14	Childcare Worker	24	Part Time Temporary	3 years 4 m	National Diploma in Applied Social Studies in Social Care
#15	Childcare Worker	32	Part Time Permanent	3 years 3 m	Diploma in Counselling
#16	Childcare Worker	39	Full Time Temporary	3 years 2 m	National Diploma in Applied Social Studies in Social Care
#17	Childcare Worker	32	Part Time Permanent	3 years 1m	BA in Applied Social Studies in Social Care, Diploma in Nursery Nursing
#18	Childcare Worker		Part Time Temporary	2 years 10 m	Diploma in Social Studies
#19	Childcare Worker	24	Part Time Temporary	2 years 4 m	National Diploma in Applied Social Studies in Social Care
#20	Childcare Worker	24	Part Time Temporary	2 years 4m	National Certificate in Applied Social Studies in Counselling
#21	Childcare Worker		Part Time Temporary	1 year 10 m	Bachelor in Religious Science with Higher Diploma
#22	Childcare Worker	24	Part Time Temporary	1 year 8 m	BA in Applied Social Studies in Social Care
#23	Childcare Worker	24	Part Time Temporary	1 year 6 m	BA in Applied Social Studies in Social Care
#24	Childcare Worker	8	Part Time Temporary	1 year 6 m	National Diploma in Applied Social Studies in Social Care B Soc Science
#25	Childcare Worker		Part Time Temporary	1 year 6 m	No qualification
#26	Childcare Worker	20	Part Time Permanent	1 year 3 m	B Social Science, MSW, Diploma in Nursing
#27	Childcare Worker		Part Time Temporary	1 year 2 m	MA Youth & Community Work, BA in Irish and Sociology
#28	Childcare Worker		Part Time Temporary	1 year 1 m	National Diploma in Applied Social Studies in Social Care

Eighteen of the staff had qualifications in child care. As shown in the table above, the staff group had a range of other educational qualifications, including degrees and diplomas in nursing, social work, health administration, counselling, psychotherapy, youth and community work, and social studies. They also had certificates in counselling, pastoral care, and health services and two staff were attending courses in psychology and psychiatric nursing.

There was a gender imbalance in the staff group with only two out of 28 staff being men. Its significance for the young male adolescents in the unit was noted by the managers and staff. Inspectors urge the board to persevere in addressing this issue since the male staff provide important role models for young people in care both in themselves and in their interactions with women staff.

In the inspection process the assessment of the unit's vetting of staff is achieved through the following stages: before the inspection the manager provides a list naming all staff and showing the dates of their Garda clearances and references; inspectors check the information and identify omissions; during the inspection inspectors look at a sample of the staff files in order to verify the information received. In this particular inspection, inspectors interviewed a representative of the personnel department, and examined a sample of five staff files. Within the information provided by the unit and in the personnel files seen by inspectors some omissions in the vetting of staff were found.

The Department of Health and Children (DoHC)'s guidelines, which have been in place since November 1994, require boards to have Garda clearance and three references prior the commencement of employment of childcare staff. Inspectors found that all 28 of the care staff in the centre had Garda clearances. For five of that number there was evidence that there had been delays in getting clearances, and they were received within days of their commencing employment. Inspectors were told by the representative of the personnel department that the practice of keeping a register of Garda clearances of permanent staff had recently been introduced. All but one of the ancillary staff in the centre also had Garda clearances. Inspectors were told that the centre was unable to get Garda clearance for a member of the clerical staff. Since she was working in the heart of the centre and had regular substantial access to the young people she should have been subject of Garda clearance like all the other ancillary staff.

Five care staff were employed prior to the implementation of the guidelines. Those and 10 others were appointed before the transfer of the centre to the board in 2001. Five of these had no references. Of the remaining 13, six had three references in accordance with the requirements of the DoHC, and seven had two. Of the total of 32 references received by the centre for this group of staff, 26 were received before the staff concerned commenced employment. The representative for the board's personnel department told inspectors that when centres transferred from religious organisations it was not the department's practice to look for staff references. It is worthy of note that the majority of more recently appointed staff did not commence employment until Garda clearances were in place. However, inspectors are of the view that the board's procedure for the vetting of staff is unsatisfactory and needs to be much more rigorous.

The SHB managers should determine a policy regarding the absence of references for those staff who have worked in the centre for several years, and put systems in place to ensure that in future all staff are fully vetted in accordance with the DoHC's guidelines before taking up employment. An examination of the sample of files immediately showed the deficiencies in vetting. The board should satisfy itself that this aspect of the safeguarding of young people in its care is as thorough as possible by ensuring that the systems introduced to make vetting more effective are regularly monitored. Inspectors recommend that a deadline is set for gathering the outstanding Garda clearances and references for staff, and advise the board to introduce the practice whereby each manager of a residential centre is required to verify that staff have been appropriately vetted at the point where they join the staff team, even if they have previously worked for the board in another centre.

Recommendation

4 The board should determine a policy regarding the absence of references for those staff who have worked in the centre for several years, and for other outstanding references, and ensure that the Department of Health and Children's guidelines regarding procedures for vetting staff before employment are rigorously applied in all future appointments, and that the system is regularly monitored.

4.2.5 Supervision and Support

The centre had a brief written policy on supervision, and it was fully realised in practice. The manager received supervision from her line manager monthly after he took over responsibility for children's residential services in January 2004. The childcare leaders were supervised by the manager and acting deputy manager, and in turn four of them provided supervision for the childcare workers. All the staff, including the night staff, received supervision. Three of the staff had received training in supervision.

Interviews with staff and examination of the relevant records confirmed that supervision was frequent and regular, and that it was taken seriously as a managerial responsibility by the supervisors and seen as beneficial by the staff. Inspectors commend the managers and staff for this.

Handover meetings took places at the end of each shift. Managers attended them. There were weekly staff meetings which all the staff team attended, and of which detailed minutes were kept. Staff told inspectors that they were encouraged to discuss issues and contribute to the meetings, and that they were seen as an important means of developing a team identity. Managers also had access to consultation with the senior psychologist associated with the centre and were able to discuss serious incidents before discussing them with the team.

The board had an employee assistance programme and access to occupational health support for staff. They could self-refer or be referred by the manager. Several of the staff made use of the programmes. They had been used after major incidents such as assaults on staff. The managers and staff reported to inspectors that they had found the programmes helpful.

Generally, staff spoke highly of the centre manager, and told inspectors that they felt supported and found the measures in place to support them effective and beneficial. The standard on supervision and support was well met.

4.2.6 Training and Development

The training received by staff in the centre is shown in the table below. As well as the training shown, some staff had training from sources external to the SHB in first aid, TCI, staff supervision, and facilitation skills. All of the care staff group and the centre's seven ancillary staff attended the briefing sessions on Children First.

Training of Staff in CRC – 21st May 2004

	Children First (Briefing) 27	*Fire Safety* 27	*TCI** 26	*Manual handling* 21	*Team Facilitation 2003* 12	*Care of the Carers* 9	*ICMP~* 9	*Health Promotion* 6	*Meeting Management* 5	*Staff Supervision* 5	*Behaviour Management* 3	*Attachment and Loss* 3	*Brief Intervention Skills* 3	*Induction to SHB* 3	*Health & Safety* 3	*Court & Court Skills* 3	*Child Protection* 3	*Group Work* 2	*Teenage Nutrition* 2
Manager	√	√	√	√	√	√			√	√					√	√	√	√	
Acting Deputy Manager	√	√	√	√	√	√			√								√		
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**TCI = Therapeutic Crisis Intervention ~ ICMP = Individual Crisis Management Plan*

Inspectors are of the view that it is important that the managers and some of the other staff in the centre receive further training in Children First, and are familiar with the SHB implementation of the national guidelines. The SHB policy on physical restraint is that Therapeutic Crisis Intervention (TCI) is the only approved method of crisis intervention, and that all staff working directly with children and young people should be trained in its use. Three of the staff had not received TCI training. In order to meet this objective the board should arrange TCI training for those staff in the centre who have not received it.

Recommendation

5 The board should ensure that further training in Children First is extended to managers and other staff in the centre, and that those who have not received training in TCI do so.

The centre had a policy on induction of staff. It was realised in practice. New staff were given a few days at the commencement of employment to familiarise themselves with the building, the staff team, the young people and the centre's policies. One member of staff gave a detailed account of induction. Supervision took place every three weeks initially, and went to every

four weeks once he had settled into the role. His induction was complemented by training in TCI, attachment and loss, fire safety, Children First, and manual handling. The introduction to the centre was thorough, systematic and gradual, and the member of staff found the process helpful.

Managers informed the inspectors that eight of the centre staff were attending college during the year prior to the inspection. The board did not cover their fees, but they were given five days study leave and exam days off. The number attending courses had an impact on staffing, with some working as few as eight hours per week. While the centre managers want staff to have the opportunity to gain appropriate qualifications the number was difficult to manage, and the intention was that only two staff would be freed to complete their courses next year. The manager emphasised to inspectors that she supported her staff in attending college because she had a good team and wanted to keep them.

4.2.7 Administrative files

The centre's recording systems were well organised, maintained to a high standard, clear, and accessible. Staff were diligent in their record keeping. Further reference to the records is made in 4.5.10 below. Overall, the system was good and the standard was well met.

4.3 Monitoring

The Health Board, for the purpose of satisfying itself that the Childcare 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 units.

The SHB has appointed two monitors for its residential centres in accordance with *Childcare (Placement of Children in Residential Centres) Regulations, 1995, Part III, Article* 17. The monitor for the centre had her first visit to the CRC in January 2004. She made four further visits between then and June 2004. During her visits she looked at the following issues under the *National Standards for Children's Residential Centres*: children's rights, purpose and function, the suitability of the accommodation, fire safety, social work visits, care plans, care files, sanctions, complaints, the centre's anti-bullying policy, unauthorised absences and education.

In interview the monitor told inspectors that all but one of the recommendations she had made after visits had been acted on. The exception was the review of sanctions. She said that the SHB monitors had issued a statement to all centres since there was some confusion about the monitors being routinely notified of all significant events in accordance with criterion 3.7 of the standards. The monitor told inspectors that she intended to visit the centre every 6 to 8 weeks. She would also carry out extra visits if an issue of concern arose. She endeavoured to see one young person on each visit, depending on the commitments of the young people. Vetting of staff has come up as an issue in monitoring visits.

Monitoring reports were sent to the manager and the line manager for the centre. The monitors were supervised by a child care manager from another area who was responsible for overseeing the board's monitoring function. Copies of the reports were also sent to the Chief Inspector of SSI.

She said that the centre was well-run, and the young people were well and safely looked after, - but in a totally unsuitable building. She told inspectors that the centre was characterised by a well-led and committed staff team for whom the young people were a priority.

Inspectors welcome the appointment of the monitors. They noted that the recommendations made by the monitor after each of her visits had been acted on, and commend the manager and staff for their response to them. The standard of monitoring was good.

4.4 Young people's rights

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

The unit had a set of clear policies on children's rights. They were based on the *United Nations Convention on the Rights of the Child* and the *National Standards for Children's Residential Centres*.

4.4.1 Consultation

Inspectors found that practice in relation to consultation in the CRC was good. The staff and young people confirmed they were consulted age-appropriately on issues affecting their daily lives, and that they were able to exercise choices about activities. Young people were asked to choose colours for their bedrooms and other parts of the house.

The unit had a 'Young Person's Views and Opinions Policy'. It detailed ways in which young people's views were sought, and emphasised the importance of giving young people feedback about the decisions to which they have made an input. The unit had a policy that young people's meetings were scheduled to take place every week. Records showed that the frequency varied. There were 17 meetings between January and May 2004. Staff said that sometimes meetings were not held owing to difficulties presented by the mix of the group, but they had become regular during the ten weeks prior to the inspection. The meetings were well attended by young people. The minutes showed that young people were able to bring their own issues to the meetings and attempt to resolve difficulties. They set their own agenda, and were involved in taking minutes. Issues raised at the meeting were discussed at staff meetings, and feedback from them was returned to the young people. Each young person met with a keyworker at least once a week, and that was described by the staff and young people as a time when consultation took place. The young people said that staff consulted with them during day-to-day interactions. They were able to exercise choice about a range of topics including: the centre's décor, menu preferences, house rules, and holidays.

Overall, there was evidence of good practice in respect of consultation with young people, and the standard was met.

4.4.2 Complaints

The centre had a document on complaints based on an old Mercy Child Care Services policy. It had been recently revised. It made a clear distinction between complaints which fall within child protection guidelines and those that did not. It gave a range of ways in which a young people could raise dissatisfaction with a service they were receiving or bring to staff attention any matter that bothered them. They were encouraged to raise matters of complaint at any time: at meals, in house meetings, to individual staff in keyworker sessions, or at bedtime. It concluded: 'the key to resolving complaints and unease among children is allowing them time and space to air their grievances and taking even the most minor complaint seriously, listening to them, supporting them through it and following it up afterward to ensure it had been suitably and successfully resolved'.

The policy was accompanied by a flow-chart for young people with colour illustration showing the process for dealing with complaints, and a page on which could be written the names, addresses and phone numbers of people outside the centre that they could contact to talk about something that bothers them. The list included members of the family and friends. It did not include young people's social workers even though they are mentioned within the process as the next people to refer the complaint to if a young person is unhappy with the way in which the centre staff and manager have handled it. Inspectors advise review of this list as some of those listed, such as the SSI, do not investigate complaints, and the Ombudsman for Children becomes involved at a later stage only if the complainant is unhappy about the way in which the immediate system responded to the initial complaint. It is suggested that the list should include the young person's social worker as someone a young person can contact independently if they have a complaint. The flow-chart identified those to whom an appeal could be made if a young person is not satisfied with the centre's resolution of the complaint.

Between July 2003 and the time of the inspection there were 28 complaints about the service in the centre made by seven young people. These were dealt with thoroughly using the centre's procedures. Details of the complaints were recorded in individual care files and in a complaints register. All but one of the complaints was made using a complaints form, and the register of complaints showed what action had been taken, and whether or not the young person was satisfied with the outcome. The register did not record some of the actions and outcomes, and it was unclear in those instances whether or not the complainant was satisfied. Inspectors advise that it be more diligently kept so that it becomes a reliable record. The records showed that eight complaints were about threats, bullying and hitting by other young people. Seven were complaints alleging unprofessional conduct on the part of staff. The centre manager, in some cases after taking advice from senior managers or the monitor, investigated them all. One of these complaints resulted in disciplinary action. Only one of them remained unresolved due to circumstances beyond the centre's control. In another the outcome was unsatisfactory to the young person and her mother. On the advice of the monitor the centre manager was due to see both of them again to see if there could be any further resolution. The other 14 were about the routines, food, pocket money, property going missing from young people's rooms, going to the cinema, and young people entering each other's bedrooms.

Young people told inspectors that they trusted the staff, and knew that they could bring any worries to them. They also knew that they could make calls in private and discuss things they were unhappy about with people outside the centre.

Inspectors were of the view that in general complaints were handled well in the centre, and there was clear evidence that the young people thought it worthwhile raising them with staff. They advise a review of the information for young people since the flow-chart is complicated and the document describing the complaints process needs to be in more accessible language.

4.4.3 Access to information

The centre had a policy on young people's access to information. It was based on Article 8 of the United Nations Convention on the Rights of the Child, the Freedom of Information Act 1997, and the SSI practice guidance notes. It made a distinction between three types of request. Sight of the care files in which are kept records produced by the centre may be accessed by the young person approaching a keyworker. For information from the case files a young person would make a request of the social worker. A young person on the point of leaving care or having left care who wishes to see all or part of the relevant files would be required to make a request through the child care manager, who in turn would discuss the request with the health board information officer.

Staff told inspectors that young people were encouraged to read their daily logs, but they were not keen to do so. Staff go through reports they prepare for reviews with young person. The manager said that staff could be more pro-active in promoting this right. If a request were made to see information that involved a third party the centre would always ask permission of the author before letting a young person see it. There was less clarity about third parties mentioned in reports such as social histories. Sometimes information was put in a confidential section of the care file because it was regarded as sensitive and could not be shared immediately. In the policy document it stated that access to information would be granted on a need to know basis giving due consideration to the age, development and understanding of the young person.

Inspectors found that in practice, although young people were aware that they could see their records, few did; and they agree with the manager that the centre could do more to promote the exercise of the right. Firstly, the policy should be revised so that there is greater clarity about ways in which young people can be encouraged to access relevant information, particularly that contained in their care and case files. Secondly, there should be included in the policy a clear definition of third parties, and a statement about the related duty to protect personal information on individuals. Thirdly, the board and the centre staff should consider in detail how and by whom judgements are to be made about the reasons for restricting access on the basis of a need to know or on an assessment of the development and understanding of the young person. The criteria for such judgements should be clear, and a record should be kept of decisions made under them.

Recommendation

6 The centre manager, in consultation with the board, should review the centre's policy and practice on young people's access to information.

4.5 Planning for 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

The centre had a written admissions policy. As indicated in 4.2.1 above, it also had an admissions committee. In practice, an admission to the centre was considered by the committee after receipt of a referral from a social worker written on a specifically designed form. This was accompanied by a care plan. The referring social worker was required to attend the committee's meeting when the referral was being considered. The committee met whenever necessary, but also kept in touch and consulted each other between meetings.

During the year prior to the inspection there had been five admissions, two of which were re-admissions of young people who had previously lived in the centre. At the time of the inspection one young person was having overnight visits as part of his gradual introduction to the centre. Inspectors interviewed him, and found that he was fully aware of the procedure, and had been given, in his view, sufficient time to adjust to his new surroundings. He was happy with the two keyworkers assigned to him, and felt that the staff were people he could trust. He was above the age of 15 specified in the admission criteria as a threshold for admissions, but his move to the centre was to facilitate continuation in a local school and maintain links in the local community after a previous care placement had broken down.

The manager said that care was taken when making decisions about admissions to ensure that the mix of young people in the unit would not adversely compromise the well-being of individual group members. The procedures emphasised the importance of letting young people already resident in the centre know when it has been decided that another young person is coming to live with them. Wherever possible, parents were also involved in the admissions process. Inspectors found that the procedures for admissions were followed closely, and that the overall standard on admissions was good.

4.5.2 Statutory care plans

Four out of the six young people in the centre had written care plans. The plans for three of them had been prepared within the statutory timescales. Of these, two were of good quality while the other pre-dated the placement by several months and was incomplete. The social worker told inspectors that a subsequent care plan was drawn up a month after the admission of the young person to the centre, but the centre had not received a copy of it. The fourth was for a young person who had been in the centre for nearly six and a half years on a shared care basis, spending four days a week with a parent and the other three days a week in the centre. Her care plan had been prepared six weeks before the inspection.

Of the remaining two young people, one had been in the centre for several years and did not have a care plan during that time. At the time of the inspection he was aged 19 years, and there was an after-care plan for him to move into third level education. One received respite care for one night every six weeks. There was no written plan in the centre's care file, even though this arrangement was respite from a foster care placement, had been in place for nearly four years and was intended to last for another four years, and review meetings took place to which the keyworker, who worked with the family, was invited. Inspectors recommend that the centre should have a copy on its care file of a care plan in which this arrangement is identified as an integral part of the young person's long-term care.

Inspectors were pleased to note that monthly return forms sent by the unit to the childcare information officer of the board referred to in 4.2.2 above required information on the number of young people in the unit with allocated social workers, along with details of whether or not they had care plans, and how frequently statutory care plan reviews were held.

Generally, the more recently admitted young people had care plans in accordance with the regulations, but inspectors recommend that principal social worker ensures that the centre has copies of all current care plans.

Recommendation

7 The principal social worker should ensure that the centre has copies of the current care plans for all the young people in its care.

4.5.3 Statutory care plan reviews

Inspectors found that regular care plan reviews had been held for all of the young people, but for four these fell within the statutory timescales, and they did not for the two who had no care plans in place, as indicated in 4.5.2 above. However, meetings were held for all three of them. The gaps between review meetings for two of the young people were 16 and 20 months.

Three of the young people attended all of the meetings, and three attended only part. All of them were assisted in preparing their own reports for the reviews, and all had keyworker reports presented by the centre. Parents attended three of the reviews. The outreach worker

attended for the three young people with whom she was working and in one case provided liaison between the meeting and the parent who could not attend. The senior clinical psychologist attended the reviews of three full-time residents, and a child psychiatrist or his representative attended two. Reports from schools were presented at reviews of three of the young people, and from social workers at reviews of two. Social workers told inspectors that members of the social work department not directly involved in the cases chaired reviews. Minutes of some of the reviews were found on four of the care files. These were of variable quality. Staff informed inspectors that the parents of three young people and the foster carers of another received minutes.

For two of the young people the centre implemented the plans through decisions made at regular monthly core group meetings. These were described by the manager as professional network meetings designed to co-ordinate, communicate, plan and review care. The senior clinical psychologist attended the meetings, as did a parent of one of the young people, a representative of the child and adolescent psychiatrist, and a representative from education.

The young people themselves did not attend. Inspectors found comprehensive placement plans on the care files of two young people. These were concerned with spelling out the practicalities of the care plan as it applied to the placement.

As with care plans in 4.5.2 above, the more recently admitted young people's care plans were reviewed in accordance with the regulations, but inspectors recommend that principal social worker ensures that all reviews of young people are within the required timescales, and that the centre has copies of all review minutes

Recommendation

8 The principal social worker should ensure that all care plan reviews are held within the statutory timescales and that the centre and parents receive copies of minutes of all review meetings.

4.5.4 Contact with families

Practice in regard to contact with families was good. In spite of many difficulties staff encouraged and facilitated contact for the young people. In one instance, where there had been no family contact for a long time, the outreach worker was establishing contact and acting as an advocate for the young person. The young people were able to make contact by phone, and three did so weekly and another monthly. Some of the visits to families were supervised, and two of the young people could see members of their families on neutral ground away from the centre. Inspectors found that decisions about supervision were made on the basis of an assessment of the risks involved, and that the reasons for these arrangements had been carefully considered and reviewed within the care planning process. Others visited their children in the centre from time to time. There was a comfortable sitting room on the ground floor of the main building where young people could meet their families in private. Inspectors found evidence that the centre staff kept parents informed of significant events and involved them in decisions concerning their children much as possible. Two of the parents interviewed by inspectors said that the staff respected them and made them feel welcome when they visited. One parent described the care in the centre as 'brilliant'. The centre staff are commended for the standard on contact with families.

4.5.5 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 on concerns they have in relation to any aspects of their care.

All of the young people had an allocated social worker. The frequency of visits by supervising social workers varied considerably. For two of the four full-time resident young people visits were within the statutory timescales in the months before the inspection. However, for the other two there were gaps in visits of six and eight months respectively within the year prior to the inspection. For the young person in shared care there had been only two visits in 2003 and one in 2004. This reflects the fact that she was at the centre only for three nights per week at weekends, and that the social worker visited her elsewhere during the week. For the young person receiving respite there were no recorded visits to the centre. This raises the question of how the suitability of the arrangement is assessed and the placement supervised. Inspectors recommend that visits for both of these young people are in place and occur regularly.

Social workers told inspectors that they received notifications of significant events, and said that the standard of communication with them and the centre was extremely good. Comments about the method of notification that were raised by the social workers interviewed by inspectors are referred to in 4.2.3 above.

Only one of the social workers said that she read relevant records in the centre from time to time. Inspectors recommend that all supervising social workers do so in accordance with the standards.

Recommendation

9 The principal social worker should ensure that all supervising social workers visit the young people in the centre regularly and read the care records from time to time in accordance with the standards.

4.5.6 Emotional and specialist support

The centre had a system of keyworking. Each young person had two keyworkers, and the young people had meetings with them twice a week that were recorded in detail. The acting deputy manager of the centre monitored the work of the keyworkers. Staff interviewed by inspectors described the tasks entailed in the role as: ensuring appointments, liaising with families, doing direct work on subjects such as an anti-bullying programme, social skills, ceasing smoking, and health-related issues. The sessions were informally structured, and it was fine if a young person just wanted to spend time with a keyworker and have individual attention.

Inspectors observed interactions with the young people that were characterised by warmth and respect. The young people interviewed said that their keyworkers were good and they trusted them. They also said that there were a lot of nice staff, that their privacy was respected, that staff were "fair and impartial", and that they 'helped you out' and taught life skills. One member of staff was described as "always kind". Another mentioned feeling looked after when there was a risk of self-harm.

The centre manager told inspectors that generally there were no difficulties in accessing specialist services for the young people. The young people's emotional needs were given prominence within the care planning and placement planning processes, and in the core group meetings, and staff endeavoured to assist the young people in finding appropriate ways to understand their psychological needs and express feelings.

The centre had a dedicated senior clinical psychologist. He served three centres in the NLCCA. His primary role was to promote the psychological health and development of young people placed in the centre. He attended some staff meetings, and was a consultant to keyworkers. He met with the centre manager, and in recent times produced a record of his consultancy that went back to the centre. He was a member of the admissions committee, and he attended core group meetings and reviews. He saw individual young people, and had provided training to the staff groups on issues chosen through a process of negotiation with the staff such as behaviour management and individual crisis management plans. The training on behaviour management came about because of his own concern that staff might be emphasising the use of sanctions too much. He said that some of the young people referred to the centre presented serious challenges in a mainstream residential setting. He told inspectors that the building and the mix of young people put some limitations on the scope to develop therapeutic input in the centre. However, he thought that the staff in the centre provided a very good service and underestimated their therapeutic effectiveness. The manager and staff of the centre told inspectors that they put a high value on his support.

Individual young people in the centre were able to access psychiatric assessment and treatment without difficulty. Two of the young people were on medication prescribed by a psychiatrist. The centre staff liaised with the representatives of the child psychiatric service frequently through the core group meetings and reviews, and they were able to make contact by phone if the need arose. They provided feedback on any observations made, particularly in respect of young people's reaction to medication the psychiatrists may have prescribed.

Other specialist services accessed by the young people included a speech therapist and eye specialist. Generally, the standard on emotional and specialist support was well met.

4.5.7 Preparation for leaving care
4.5.8 Discharges
4.5.9 Aftercare

The centre had programmes to assist the young people in learning life skills such as budgeting, shopping, cooking, self-care, personal hygiene, maintaining good health, and sexual health and relationships. There was an outreach worker who shared her time between the CRC and two other centres. She and the centre manager told inspectors that the staff did a lot of work to prepare the young people for leaving care. She was involved with two of the resident young people and an ex-resident. She described her role as linking with families and assisting young people in transition between one placement and another, and saw it as distinct from aftercare. She said that most referrals for outreach came from the team meetings in the centre. She was seconded to the role, and her secondment was due to end in September 2004. The ex-resident with whom she was working, and others, knew that they could check in with the staff, even in the absence of a formal aftercare arrangement.

During the year prior to the inspection four young people had been discharged. One, aged 21, went into independent living. Two, aged 15 and 19 years, returned to the care of their mothers. The other was transferred to a high support unit.

There was one young person in the centre for whom an aftercare plan had been devised. As part of his preparation for leaving he was going out to work. He told inspectors that he was helped to prepare for leaving by being taught life skills. He had also been encouraged in his education, and was able to consider the option of third level as a consequence of his success in his leaving certificate examinations. The SHB has an aftercare co-ordinator, and his after-care plan will be sent to her for approval. Her role was described as advisory rather than offering a service. Inspectors also interviewed an ex-resident who had been discharged from the centre in 1999 at the age of 19, and was re-admitted in 2001 after a period of independent living. She was living in the community again, semi-independently, since February 2004, but was not officially discharged from the centre. In the absence of an allocated social worker, the centre staff were engaged in finding suitable sheltered accommodation for her.

Inspectors are of the view that the centre went well beyond its stated purpose and function in continuing to provide care for two young adults over the age of 21 years, and others who had reached the age of 19. It is a testimony to the centre staff that they remained committed to the young people in their care after they reached adulthood, in accordance with the standard, and responded to their vulnerability. Their service to these young adults was given in the absence of any aftercare provision offered by the board. Inspectors recommend that the SHB produce a written policy clearly stating all aspects of support and entitlements for a young person leaving its care, and that it develops after care services which can deliver them.

Recommendation

10 The board should develop a written policy clearly stating all aspects of support and entitlements for a young person leaving its care, and establish aftercare.

4.5.10 Young people's care records

Inspectors found that the care files were of a high standard. Records produced by the unit staff were detailed and complete. All the young people's files contained relevant documentation including care plans, birth certificates, care orders, medical information, and school reports. All files contained social histories which had been written to accompany the referral form, or for court proceedings or for a case conference. They were of good quality. The care planning process had a dedicated section in the files and was easy to track. Notifications of significant events were recorded clearly.

Generally, the files were well organised, and there was a common standard and style of recording. The system was clear, diligently maintained, accessible and accountable. The staff in the centre are commended for its quality.

4.6 Care of Young People

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. 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

Staff interviewed by inspectors described a typical day in the centre. The young people rose at different times between 5 a.m. when the oldest of them had to get up to go to work, to mid-

morning for one young person. They had breakfast at different times depending on when they needed to be off to school. One of them received breakfast at school. Cooked breakfasts were provided occasionally. Lunch was at 1.00 p.m., and everyone sat to this meal together. At evenings and weekends the young people helped in the preparation of meals. They were able to make snacks for themselves, but were discouraged from doing so after 9.00 p.m. Three of them arrived back from school at different intervals between 2.30 p.m. and 4.00 p.m. One of them had homework to do. She was given time to unwind after returning from school, and then staff offered help with homework if she requested it. Tea was at 5.30 p.m. The young people were consulted about the menu, and were often given choices of meals. Occasionally they would have takeaways or meals out with keyworkers. In the evenings there was a wide range of activities including meetings, keyworker sessions, walks, drives out, games, pool, table tennis, drawing, painting, computer, TV, and an exercise programme. At weekends the young people sometimes went to the cinema. In summer the bedtimes ranged between 10.30 and 12.00 am, except for the oldest resident who decided for himself when he should go to bed.

On Fridays the shopping for the week was done. Staff and young people took it in turns to go to the supermarket. Toiletries were not part of the general shopping. Instead they were bought by the young people when they were out with their keyworkers. Some make up was bought by the centre, and some out of pocket money. Pocket money ranged from €14 per week given to one young person as €7 twice a week, to €8 for the youngest. The young people told inspectors that they could spend it as they wished. Clothing was bought when out with keyworkers, as required. The allowance for it amounted to €250 per season. The young people could also buy clothes on special occasions. They were allowed to choose where they bought them, and cash was used to purchase them. Two of the young people had mobile phones for which the centre provided credit.

Telephone calls could be made in private. Staff said that they were sometimes supervised at the request of the young people. Otherwise, if they were supervised because of a perceived risk the decision to do so would be taken at the core group meetings, or the decision to supervise was made in consultation with social workers, and recorded. They were able to invite friends to stay, but few did, and some of them were able to stay over with friends. When requests to stay with friends were made the centre staff carried out checks to ensure that the homes in which the young people were staying were suitable.

Birthdays were celebrated by a party or an outing with family and friends. At Christmas most of the young people went home for the day. The centre had a Christmas dinner for those who could not go home, and another on New Year's Day for the whole group. One of the young people attended her sister's First Holy Communion. The centre paid for her to have her hair done, and brought her to the ceremony. Another young person had an extra night at home when her sister had confirmation. At another time, when young people in the centre received confirmation, everyone went to the ceremony, and they came back to the centre with the young person's family for a meal, and then had an outing, -depending on the circumstances.

Memorabilia and personal belongings were kept safe for young people, and given to them when they leave.

The young people had their own bedrooms. They were painted and personalised according to the taste of each young person. It was a matter of concern and discussion, and some young people brought it to the attention of the inspectors that others broke a house rule by entering their bedrooms. The staff dealt with this through discussion and vigilance.

Some of the young people interviewed by the inspectors said that they did not like staff having to check up on them particularly at night. These checks were based on risk assessments related

to the potential for self-harm. When asked if the measures were reasonable, even if they did not agree with them, the young people said that they were, and they understood that they were done in order to ensure their safety.

4.6.2 Provision of food and cooking facilities

The inspectors shared meals with the staff and young people. Young people and staff had meals together in a convivial atmosphere. Young people were able to exercise choice and personal preferences were catered for. The food on offer was plentiful and varied. The centre had a cook who worked 34 hours per week. Owing to the particular circumstances of some of the young people the CRC staff sought advice on dietary requirements, keeping in mind the need to be sensitive to how eating and diet impacted on the self-image of young people.

On the ground floor at the rear of the main building there was a large commercially equipped kitchen. The dining room, situated at the front of the building, was reached from the kitchen through a dog-leg corridor and part of the central space below the main stairs. For some meals this entailed everyone who was eating having food plated up in the kitchen and walking to the other side of the building. While this worked and there was general satisfaction with the provision of food it nonetheless was an institutional arrangement. Inspectors suggest that the managers of the centre give consideration to how meals could be more like those experienced by the peers of the young people in the community.

4.6.3 Race, culture, religion, gender and disability

The young people were facilitated in the practice of their religion. Staff told inspectors that the young people were encouraged to attend Mass, and some did. At Christmas the feast was celebrated with a house Mass for young people and staff, and periods in the church's calendar were marked through means such as the hanging of an advent wreath. The centre had ascertained the wishes of parents for the more recent admissions. The acting deputy manager told inspectors that staff were looking at ways to promote spiritual welfare. There was a list of assigned tasks in the staff room that was drawn up monthly, and one of them was spiritual development.

The centre recognised the importance of the family as a source of heritage and identity. Appropriate information about the family was shared with the young people, and all opportunities to promote positive contact were taken. Unit staff are commended for their work with the families of the young people.

4.6.4 Managing behaviour

The manager told inspectors that the basis of the centre's behaviour management was the relationships built up between the staff and the young people. The centre had a policy that listed permitted and prohibited sanctions. It also had a 'supervision of children' policy that put an emphasis on ensuring an adequate level of 'parental' supervision. Inspectors examined the sanctions log book and found that they were used sparingly. One of the sanctions, early bed, was removed at the suggestion of the monitor. The centre was reviewing all the sanctions in the light of a recommendation made by the monitor. The centre also used Individual Crisis Management Plans (ICMP) in order to assess the risk of certain behaviours and have a planned response for serious issues of control. As indicated above, training in ICMPs was provided by the senior clinical psychologist.

Inspectors were told by staff that there had been a period in February and March when behaviour of some of the young people was very challenging, but they had come through that

without discharging the young people concerned, and believed that they had 'weathered the storm'. Generally, the standard on managing behaviour was well met.

4.6.5 Restraint

The SHB had a policy that Therapeutic Crisis Intervention (TCI) was its only approved method of crisis intervention, de-escalation of conflict and physical restraint. All but three of the staff were trained in TCI.

During the year prior to the inspection there had been four episodes of physical restraint. Three of these were standing holds that occurred during disturbances by the young people in the night. They were appropriately recorded, and notifications were given to the child care manager, social workers, parents, and the senior clinical psychologist.

4.6.6 Absence without authority

The centre had a detailed written procedure for unauthorised absences. It drew from the policy produced by Chief Executive Officers of the health boards in 2002. It emphasised the importance of making a risk assessment so that specific measures for each young person can be incorporated into their care and placement plans. During the year prior to inspection there had been 45 unauthorised absences. They ranged between ten minutes and 47 hours, with fifteen of them being for periods of less than an hour. The shorter periods were classified as unauthorised absences in part because the vulnerability of the young people who went missing was such that they were considered at risk as soon as they were away from staff supervision, and because the geographical location of the centre and the extent of its grounds made searching beyond the house impracticable particularly at night. The absences were appropriately recorded, and notifications were given to the child care manager, social workers, parents, and the senior clinical psychologist. The standard on unauthorised absences was met.

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.

4.7.1 Safeguarding

The unit had a written policy on safeguarding. It covered the safeguarding features listed in the standards, except informed therapeutic interventions. It included brief statements about the anti-bullying and sanctions policies. The unit also had a recently prepared written policy on professional relationships between staff members and young people.

There had been one incident in which a staff member had said something inappropriate to a young person. This was investigated by the centre manager and resolved.

There was an emphasis on security of young people and staff within the centre. The need for professional boundaries was understood and influenced practice. The need for vigilance, and occasionally extra staffing in order to safeguard young people from some of their peers was also clearly understood. Most of the staff interviewed by inspectors showed an understanding of the policies and principles of safeguarding. However, there was some confusion about the principle that safeguarding is primarily for the protection of children and young people rather than the protection of staff. Practice in safeguarding was consistent with the centre's policy and to standard.

The centre had an anti-bullying policy. It was a SHB policy for residential centres dated May 2002. It defined types of bullying and their effects, and emphasised the creation of an environment in which bullying is not tolerated in any form as well as one in which all incidents will be dealt with whether they occur in the centre or elsewhere such as in school. It did not include notification to the social worker, or the treatment of bullying in some instances as a child protection concern. Inspectors recommend that the policy be revised in order to incorporate these features. The register of complaints in the centre showed that from time to time threats and bullying between the young people happened in the centre. The staff dealt with each incident as it came to their notice. They also did individual anti-bullying programmes in keyworker sessions in order to equip young people to deal with it.

Recommendation

11 The board should revise the anti-bullying policy incorporating notification of bullying incidents to social workers and putting it within the framework of child protection.

4.7.2 Child protection

There are systems in place to protect young people from abuse. Staff are aware of and implement practices, which are designed to protect young people in care.

The centre had a written policy on child protection, endorsed by the board. However, it was clearly based on Children First, and required the centre staff to pass allegations of abuse on to the childcare manager and the social work department. The centre used the standard notification form for child protection issues.

Staff were clear that they should immediately tell the manager if abusive behaviour had been disclosed or an allegation made, and record it. All but one of the staff group had received briefing in Children First. Inspectors are of the view that they should receive full training in Children First. This is subject of a recommendation in 4.2.6 above.

Inspectors were told of four child protection concerns that had been notified during the year prior to the inspection. They were about situations and people that the young people met outside the centre, and did not involve members of staff or other young people in the centre. One was referred to the Gardai, and the others were being assessed by social workers.

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.

All of the young people in the centre attended educational facilities. The oldest, who had completed his leaving cert in seven subjects in 2003, had repeated maths in order to get into college. He was working during the summer but it was planned that he would attend college in Cork or Kerry in the autumn, depending on his result. The centre supported him in this by arranging maths grinds for him. Two of the young people were out of mainstream school and attended the Cork Tuition Centre. One was excluded from school because of behavioural problems rather than learning difficulties, and the other had learning difficulties and a hearing impairment, and refused to attend school. Another young person attended special school because of a learning disability. She also received speech therapy. The youngest attended post-primary school and received help with maths from a remedial teacher.

Inspectors found that the staff in the centre valued education highly and supported the young people in meeting this need. Staff liaised with teachers and attended school meetings and events. The parents interviewed by inspectors received copies of school reports. The standard on education was met.

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 centre had a GP who was female. She was based locally and responded to requests from staff for visits and appointments. All of the young people in the centre were registered with her. The centre manager said that sometimes specialist medical consultancy could not be accessed quickly. Inspectors recommend that the board ensure that young people in its care are given priority in accessing specialist services as they need them.

There was a non-smoking policy. Young people were allowed to smoke outside the building, but they were also actively encouraged to quit through a programme provided by the keyworkers.

A worker from a sexual health agency and the keyworker were working together with young person to cover the topic of sexual health. Two staff had training in it. The manager told inspectors that her plan was that all staff should receive training in order to be able to deal with young people's queries.

Recommendation

12 The board should ensure that children in its care are given priority when accessing specialist medical services.

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 unit has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Childcare Regulations, 1995.

4.10.1 Accommodation

The centre's accommodation was based in a Victorian house in its own grounds. The managers' and staff's offices and the bedrooms for girls were in the main building, and there was an annex in which there were rooms for boys. At the rear of the building there were several rooms and interconnecting corridors that represented different periods of its history and past uses. At one time many of the rooms were classrooms. The majority of them were no longer in use, and there was a disused chapel within the main building. In the interests of fire safety, the second floor of the building was no longer in use following a recommendation by a consultant engineer. The main building had recently been painted, and although neither the interior nor many of its furnishings were modern efforts were made to maintain a standard. The boys' accommodation was in a single storey suite of rooms that were built about forty years ago and had not been refurbished since. They were connected to the main building by a corridor/bridge from the first floor. There were gardens and other land around the building

including a defunct playground with rusty equipment that was no longer in use because it was unsafe.

The girls had large individual bedrooms and four bathrooms off the main landing on the first floor. The boys had individual rooms, a bathroom and two shower rooms in the annex. There was a staff office at the top of the stairs in a central position in the main building. There was one staff sleep-in room in the annex. The laundry was situated at the end of the annex. It had domestic washing machines and dryers. On the ground floor of the main building were: a room with computers and a telephone where young people could receive calls in private; a large lounge with settees which was used as a television room; and another room with comfortable furnishings where young people could meet visitors in private. At the side of the building in the old school area there was a large games room with a table-tennis table and two pool tables. There was also an enclosed hard-surfaced play area.

Although the majority of staff and other professionals agreed that the building was not suitable for its purpose, one of the young people spoke of it with great affection, and those who had lived there for many years thought of it as home. However, inspectors were of the view that for all its charm the building was too large and institutional for its current purpose and function, and no longer in keeping with best practice in that it was a considerable remove from the normal experience of home life of young people in the community. The child care manager told inspectors that the board acknowledged the unsuitability of the building and was in the process of determining the best way to transfer the service to more suitable accommodation. Inspectors recommend that priority be given to this process.

Recommendation

13 The board should give priority to transferring the centre to more suitable premises.

Inspectors were given written confirmation that the unit was covered by an insurance policy for public liability, and employer's liability. The policy was due for renewal on 1st January 2005. They were also given written confirmation of another insurance policy covering the building that was due for renewal on 30th April 2005.

4.10.2 Maintenance and repairs

The centre had its own full time maintenance man. Larger jobs were carried out by the health board's maintenance section, and inspectors were told that sometimes there were delays in responses to requests.

4.10.3 Safety

The centre had one health and safety staff representative. Inspectors found that staff's general awareness of safety was extremely good. A health and safety audit was carried out monthly by the unit manager in accordance with the SHB policy. The last check before the inspection took place on 21st May 2004. Identified hazards were dealt with as soon as possible after each audit.

Managers told inspectors that the board had assigned a fire and safety officer to assist managers of all the board's children's residential centres in carrying out health and safety assessments. Inspectors welcome this development, and commend the board for its imaginative solution to the problems it faced when responsibility for health and safety assessments moved from the safety advisors to the centre managers.

The centre had a health and safety statement. It had been updated in May 2004. It did not name any person with responsibility for the health and safety of the centre, and it was unsigned. However, it had a hazard identification and control list that was drawn up by the manager in consultation with the staff. It had a statement about the management of stress that referred to other of the centre's policy documents, most notably one entitled 'Caring for the Carers' which emphasised the responsibility individual staff had for caring for themselves. It also gave clear guidance and instruction for staff to ensure safe practice in areas such as kitchen hygiene, the use of the grounds for recreation, and the use of the centre's vehicles.

The centre had a locked medicine cabinet in the staff office for the safe storage of medication. The young people did not have access to the room. Staff's medication was kept in lockers in another staff room. There was a written procedure for the administration of prescribed and over-the-counter medication, with a single system of recording that included a space for the signature of the young person receiving the medication. The procedure included a practice where by the keyworker would consult the centre manager and make an appointment with the GP if a young person was making frequent requests for over-the-counter medication. The procedure was clear, and realised in practice.

The staff in the centre were issued with personal alarms, which they had carried and used during a difficult period in February and March 2004. At the time of the inspection the alarms were not in use because the staff team had made an assessment and decided that the risks for which they were needed were no longer as serious.

First aid training had been received by only four of the centre staff, three of whom worked part-time. Inspectors advise that this be extended to more staff so that there can be a first aid trained person on each shift.

4.10.4 Fire Safety

Inspectors were provided with written confirmation from a qualified engineer who was a safety officer in the SHB dated March 2004 that the statutory requirements relating to fire safety had been complied with.

The centre had an automatic fire alarm and emergency lighting system. It was checked regularly. Fire extinguishers and alarm points were tested weekly, and fire doors were tested daily. Both of the centre's vehicles were also fitted with fire extinguishers. A check on the fire safety systems was carried out by the board's safety officer with particular responsibility for children's residential centres in April 2004. The centre had fire safety procedures within its health and safety statement prepared in May 2004 which gave guidance to staff about what to do in response to a fire. Inspectors examined the fire register and found that fire drills were regular and frequent, sometimes occurring two or three times a month. The frequency of fire drills reflected the concerns of the staff about the complexity of the building. The staff team regularly discussed fire safety in order to maintain a high level of awareness of the risks. All but one of the total staff group had training in fire safety. Measures were taken to ensure the young people were aware of what to do in the event of a fire, and slow responses to fire drills were dealt with in a sensitive and serious manner. There were daily routines, such as ensuring that tumble dryers were used under supervision and switching off electrical equipment at night, which gave fire safety further prominence for all staff.

In the view of inspectors, staff took a serious and well informed approach to fire safety, and were diligent in carrying out frequent checks of the systems designed to ensure the safety of the young people and themselves. There was considerable evidence that the board was satisfying itself that the systems in place for fire safety were adequate.

5 Summary of Recommendations

1. **The board should review the centre's statement of purpose and function.**

2. **The board should ensure that the unit's register includes all the details required by the regulations, and that a duplicate of the information it contains is kept in administrative offices of the health board as required by the standards.**

3. **The board should review the arrangements for staffing in the centre.**

4 **The board should determine a policy regarding the absence of references for those staff who have worked in the centre for several years, and for other outstanding references, and ensure that the Department of Health and Children's guidelines regarding procedures for vetting staff before employment are rigorously applied in all future appointments, and that the system is regularly monitored.**

5. **The board should ensure that further training in Children First is extended to managers and other staff in the centre, and that those who have not received training in TCI do so.**

6. **The centre manager, in consultation with the board, should review the centre's policy and practice on young people's access to information.**

7. **The principal social worker should ensure that the centre has copies of the current care plans for all the young people in its care.**

8. **The principal social worker should ensure that care plan reviews are held within the statutory timescales and that the centre receives copies of minutes of all review meetings.**

9. **The principal social worker should ensure that all supervising social workers visit the young people in the centre regularly and read the care records from time to time in accordance with the standards.**

10. **The board should develop a written policy clearly stating all aspects of support and entitlements for a young person leaving its care, and establish aftercare.**

11. **The board should revise the anti-bullying policy incorporating notification of bullying incidents to social workers and putting it within the framework of child protection.**

12. **The board should ensure that children in its care are given priority when accessing specialist medical services.**

13. **The board should give priority to transferring the centre to more suitable premises.**