A CHILDREN'S RESIDENTIAL CENTRE IN THE SOUTH WESTERN AREA HEALTH BOARD COMMUNITY CARE AREA 3

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1. Executive summary

The Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre in Community Care Area 3 (CCA3) of the South Western Area Health Board (SWAHB) between 10th and 12th February 2004. The centre was set up in 1995 to care for children who had been living in a large residential centre that closed. It was established to provide medium to long-term residential care. The centre had the capacity for four children, but at the time of inspection there were just two children resident. They were aged nine and twelve years.

An inspection, scheduled for autumn 2003, had been deferred following the centre's unscheduled temporary closure for approximately two weeks in November 2003. The closure was done on the recommendation of the board's monitoring officer. On visiting the centre she found that there was an acute staffing shortage due to sick leave. She informed senior managers and a decision was taken that the centre should close on a temporary basis. The children had to be temporarily accommodated elsewhere. While inspectors found that the monitoring officer had acted correctly in recommending the temporary closure of the centre, this highlighted inadequacies in the internal and external management of the centre that were still apparent at the time of inspection.

The management team in the centre was not in a position to provide the staff with leadership and direction. The staff team had become preoccupied with internal team disputes to the detriment of the care of the children. The external line manager was supervising a number of different services and, despite some efforts to resolve difficulties within the centre, was not in a position to give the matter the sustained attention it required.

Of the fourteen staff, only two were permanent. There was a good level of qualification within the staff team but there were gaps in the vetting records presented to inspectors.

In the course of the inspection, inspectors found that a number of standards were well met. In particular, inspectors noted that the day-to-day care of the children was warm and appropriate. The children's routines were similar to those of peers not in residential care, and the staff were attentive to their needs. Keyworkers gave individual time and attention to each child, and advocated for them. They reported that recent training in 'Life Story Work' had been helpful. The centre's administrative system was of a good standard. In general, children's educational needs were well looked after, with regular meetings between schools and staff; and the children were helped with their homework.

The children's right to access to personal information was well promoted and facilitated, and they were consulted on day-to-day issues. Practice in relation to complaints that were dealt with internally was good, but work was needed to develop policy and practice in relation to complaints dealt with outside the centre.

Social workers visited regularly and saw the children in private.

Statutory care plans were in place for the children and statutory care plan review meetings had been held within the time frames required by the regulations. The care plans guided placement plans. However, inspectors were concerned at the length of time children who were placed in the centre at a young age were spending in residential care. One child had clearly expressed a wish for a foster placement. Social workers reported that placements in foster care were unavailable. However, during the temporary closure of the centre three of the four children were placed in foster homes.

The standard on management of behaviour prior to the closure of the centre had not been met. Subsequently, practice had improved. External managers must gauge the use of sanctions, unauthorised absences and complaints as key indicators of the well-being of the centre.

Inspectors found significant gaps in the standards that refer to physical accommodation, fire safety and maintenance of the centre. The monitoring officer reported in February 2003 that the centre had no fire certificate and that the house was in urgent need of maintenance and redecoration. These concerns had not been addressed by the time of inspection a year later.

Inspectors met with senior managers in the course of the inspection and alerted them to concerns about the management of the centre. Some changes were made prior to the publication of this report. The SSI welcomes these changes. A follow-up inspection will be carried out to assess progress in implementing the recommendations of this report within approximately six months of the publication of this report.

2. Introduction

The Social Services Inspectorate (SSI) carried out an unannounced inspection of a children's residential centre, Community Care Area 3 (CCA3), South Western Area Health Board (SWAHB) between 10th and 12th February 2004. The inspectors were Andrew Fagan (support) and Lorraine Edwards (lead).

2.1 Methodology

The inspectors had access to the following documentation:-

- Policies and procedures manual for Dublin South City Residential Centres,
- Children's care files,
- Children's daily log books,
- All administrative records,
- Census forms for staff,
- Census forms for children,
- Questionnaires completed by social workers,
- Questionnaires completed by teachers,
- Regional child care framework progress reports for 2002 and 2003, and
- SWAHB Organisational Strategy (Children and Families) Implementation Plan.

During the fieldwork inspectors interviewed the general manager, the child care manager, the principal social worker, social workers, a social work team leader, the health board monitoring officer, centre staff and one young person.

2.2 Acknowledgements

Inspectors wish to thank the children, centre staff and managers, social workers and health board managers for their support and participation in the inspection process.

3. Setting the scene:

3.1 Background

The centre was opened to care for a number of children who had previously lived in a large non-statutory children's residential centre that closed in 1995. The centre provided medium to long term residential care to children living in the former Eastern Health Board (EHB) region. Following the reorganisation of EHB the centre became a residential resource for the SWAHB.

The SSI had planned an inspection of the centre for autumn 2003, but this was rescheduled after learning about its temporary closure due to staffing difficulties. There were three children resident at the time of the closure and they were temporarily accommodated elsewhere for a period. On reopening of the centre three young people returned to the centre. However, one returned for one week only and another child, who was admitted to hospital prior to the closure of the centre, did not return at all.

Having rescheduled the date for inspection, the inspectors examined the overall standards of care at the centre, taking account of the impact of the temporary closure of the centre on the children.

3.2 Data on young people

There were two children living in the centre at time of inspection.

Children	Age	Length of Time in Centre	Legal Status	Previous Placement
Boy	13 years	8 yrs 10 months	Fit Person Order	Residential Care
Girl	9 years	3 yrs 6 months	Care Order	Foster Care

4. Standards: the findings

4.1 Statement of purpose and function

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

Inspectors were provided with a draft generic statement of purpose and function for all children's residential centres in Area 3 of the SWAHB. This had been drawn up by the residential managers but had yet to be approved by senior managers. Inspectors found no written statement of purpose and function specifically for this centre. However, inspectors were told that the centre provided long-term residential placements for four children aged seven to sixteen years. Additionally, some key policies were not underpinned by written statements. The health board monitoring officer informed inspectors that she was helping the manager and staff to develop a statement of purpose and function.

Recommendation

1. The ACEO for child care should ensure that there is a written statement of purpose and function for the centre.

4.2 Management and care staffing

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

4.2.1 Management

The residential services for CCA3 were managed by the principal social worker for that area. Inspectors were told by senior managers that the post of manager of residential services for the area had not been filled due to lack of funding. The remit held by the principal social worker was considerable. He managed six social work team leaders, a family support service, and five residential centres. Inspectors found that he could not provide the level of supervision the centre needed. For example, he was not aware of the level of sanctions and complaints at the centre.

The centre manager was responsible for the day-to-day running of the centre. She had managed the centre for nearly three years. She was also involved in work outside the centre, such as participation in a multidisciplinary group reviewing alternative care services in SWAHB. The manager also undertook joint work with the other centre managers for CCA3 such as staff training and the development of policies and procedures.

The centre had an acting deputy manager, who had been in this full-time temporary acting position for over two years. She had worked as a child care leader at the centre prior to taking up her position as acting deputy. Her role was to deputise for the manager, undertake administrative work, assist in the development of policies and procedures of the centre, and supervise a number of staff. The acting deputy manager also was rostered for one sleepover and worked two days per week on management and administrative tasks.

Inspectors found that there were serious problems in the internal and external management of the centre. There had been difficulties internally on reaching an agreement about the roles and duties of the management team. There had been little attempt to focus on agreed objectives, and there were significant difficulties in communication between individuals. This had affected the overall management of the staff on the ground. Attempts were made by the principal social worker to address the areas of concern about internal management. For example, inspectors were told that there had been meetings with external management and with the personnel department. Outside facilitation was made available and the monitoring officer was requested by the principal social worker to provide support to individuals involved in these difficulties. Despite these inputs, difficulties remained unresolved. The centre was not effectively managed, and the staff team did not get the direction, leadership and support that they needed.

During a visit to the centre in November 2003, the board's monitoring officer found that the management of the centre was unsustainable as there were insufficient staff available to care safely for the children. At that time nearly the entire centre staff were unavailable for work owing to work-related sick leave. By agreement of the general manager and the

assistant chief executive officer (ACEO) for child care, the centre was closed on a temporary basis for two weeks. The children were moved to alternative placements.

Following the reopening of the centre, the monitoring officer and principal social worker developed a schedule to support the internal managers and staff team. Inspectors were told that the monitoring officer's input had clarified the managers' roles within the centre. Despite this progress, inspectors found that there remained considerable unresolved conflicts within the staff team and concluded that a change in management arrangements was required. Inspectors met with senior managers of the health board and advised them that the management arrangements had to change or SSI would recommend the closure of the centre. A further meeting was held at which senior managers advised inspectors of their proposals for change. Inspectors welcome the proactive and positive response from the board. A further inspection of the centre will take place six months from publication of this report to assess progress made by the board in meeting the requirements of the standards.

Recommendation

2. The ACEO should ensure that there are adequate arrangements for the internal and external management of the centre.

4.2.2 Care Staffing

There was a total of fourteen staff working at the centre. They were all female, and the average age was twenty-seven years. Two of the staff were permanent, the rest were temporary. Eight worked full time and one worked half time. The remaining three staff were relief workers and their hours were determined according to need. Inspectors heard from staff that there had been an embargo placed by SWAHB on the recruitment of staff. The manager and staff told inspectors of difficulties in replacing staff, particularly during sick leave. Agency staff had to be approved via the principal social worker and agreed by the general manager at times of staff shortages.

Inspectors were not given full details of staffing, Garda checks and references. For example, information provided to inspectors showed that only six staff had dates of Garda clearances, only four staff had two references available, and details of their third references were not available. The board must ensure that all relevant checks on staff are in place.

Each staff shift started in the morning at eleven o'clock and a handover meeting occurred at this time. Staff slept over at the centre and finished their shift at twelve noon the following day. They worked in pairs, and did two shifts per week.

The majority of staff held social care qualifications, and the average length of service in the centre for those staff for whom details had been provided was three and a half years. The staff team's experience, status, and qualifications are highlighted in the table below.

STAFF EXPERIENCE, STATUS AND QUALIFICATIONS – 10th February 2004

CARE STAFF	*LENGTH OF SERVICE in CENTRE*	*EMPLOYMENT STATUS*	*QUALIFICATIONS*
Manager	2 years 9 months	Full Time Permanent	BA in Social Care
Acting Deputy Manager	5 years 4 months	Full Time Temporary	BA in Social Care
Care Worker	7 years 7 months	Full Time Permanent	National Diploma in Social Studies in Social Care
Care Worker	1 year 6 months	Full Time Temporary	BA in Social Studies
Care Worker	2 years 5 months	Full Time Temporary	National Diploma in Social Studies in Social Care
Care Worker	3 years 1 month	Part Time Temporary	National Diploma in Social Studies in Social Care
Care Worker	*(await details)*	Part Time Temporary	National Diploma in Social Studies in Social Care
Care Worker	8 years 8 months	Full Time Permanent	National Diploma in Social Studies in Social Care
Care Worker	1 year 6 months	Full Time Temporary	National Diploma in Social Studies in Social Care
Care Worker	4 years 4 months	Full Time Temporary	National Diploma in Social Studies in Social Care
Care Worker	2 years 2 months	Full Time Temporary	Certificate in Special Needs
Care Worker	2 years 6 months	Relief	BA in Social Care
Care Worker	1 year 7 months	Relief	National Diploma in Social Studies in Social Care
Care Worker	1 year	Relief	National Diploma in Social Studies in Social Care

As referred to in 4.2.1 above, difficulties within the management team diverted staff energies from the needs of the children. Much time was spent analysing management style and decisions. This led the staff team to focus their attention away from the primary care of the children. Inspectors heard that prior to the temporary closure of the centre, when many staff were on sick leave, there were few staff available to give the children the level of care and emotional support they required. Staff reported that following the reopening of the centre they worked more closely together and were more focused in their approach to the care of the children.

Recommendation

3. The general manager should ensure that Garda checks and three references are acquired for all staff prior to taking up duty.

4.2.3 Supervision and support

The principal social worker provided formal supervision to the centre manager once every six weeks. The manager also had regular meetings with the other centre managers for CCA3, and told inspectors she found these meetings helpful.

The standard on supervision requires that all staff receive regular supervision and that details are formally recorded. The manager and deputy manager supervised staff and supervision took place on a monthly basis. The staff who received formal supervision had their sessions recorded and placed on staff files. Inspectors learnt that a number of relief staff were given the choice of whether they wanted to be supervised or not, and were given

a further option of whether they wished to be supervised by the manager or deputy manager. The manager and acting deputy manager met to discuss operational issues but, from April 2003 to January 2004, the manager had not formally supervised the acting deputy. This was not satisfactory. The acting deputy manager requested outside supervision, but this was not made available.

Other supports were made available to the team. A staff facilitator that had been brought in to undertake team building and to assist the staff, through training, in managing the children's behaviour. This exercise finished in May 2003. During the summer of 2003 the principal social worker met with staff to look at difficulties, and addressed written complaints he had received from staff. Following this, he requested the monitoring officer to undertake work with the team. This took the form of facilitation at team meetings, one-to-one work with staff, and mediation. She gave guidance on the management of the behaviour of the children. She also undertook debriefing sessions with staff following the closure and re-opening of the centre. The health board's staff counsellor offered individual counselling to staff at this time. Following their interventions, individual personal staff development plans were developed with the training officer and, at the time of the inspection, the board had a plan to introduce a written policy on supervision. Team meetings were held weekly, and minutes were taken. Staff reported that they found these meetings helpful.

Whilst there was evidence that some supervision was taking place and various supports had been put in place, these were not sufficient to overcome the divisions within the staff team and ensure the delivery of a good standard of care to the children. The standard on supervision and support was not met.

Recommendation

4. The centre manager should ensure that all staff, including the acting deputy manager, receive regular formal supervision.

4.2.4 Training and development

The table below outlines training organised by the board for staff at the centre:

Training of Staff in the Centre – 10th February 2004

	Acting Centre Manager	Acting Deputy Manager	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker	Child Care Worker
TCI	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Life Story Work		√		√						√	√	√		
Trauma Model	√													
Management Development	√													

New staff participated in an induction programme which was drawn up by the managers at the centre. There had been training in Therapeutic Crisis Intervention (TCI) for all staff. The principal social worker sought training for the manager and staff that focused on direct work with the children. Some staff had an opportunity to train in this area, and inspectors were told by them that this had inspired their thinking on how to work with the children in a positive way. The principal social worker is commended for accessing this training for staff. The manager had also undertaken a management training course and had participated in a training course on trauma.

4.2.5 Administrative Files

The administrative files within the centre were well organised and systematically maintained.

4.2.6 Notification of Significant Events

Generally, communication between centre staff and social workers was good. However, the centre staff had some concerns about the lack of feedback following the reporting of significant events to social workers. This was particularly the case where social workers informed parents of significant events involving their clients.

The monitoring officer told inspectors that she was informed of significant events. For example, she was informed of assaults by children on peers. The monitoring officer advised the staff team to develop a common definition of significant events.

4.2.7 Register

The manager kept a register of all children at the centre and duplicate records were kept at the health boards' administrative offices.

4.3 Monitoring

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

A monitoring officer for all children's residential centres in the SWAHB had been appointed in September 2002. She reported to the ACEO of the SWAHB. There had been a high level of contact between the monitoring officer and this centre, and she visited and telephoned regularly. In March 2003 she sent a written report to the ACEO highlighting her concerns about the poor physical standard of accommodation in the centre and the centre's policies and procedures, and identifying difficulties for the centre caused by a centralised budget. Issues concerning care and management of the children were not apparent at this stage, but the monitoring officer told inspectors she became aware of deficits, particularly regarding the operation of overly punitive sanctions referred to in 4.6.4 below, over time.

Early in autumn 2003, the principal social worker requested the monitoring officer to undertake some developmental work with the centre, separate to her role of monitoring standards of care. This request was made because of her skills and experience in the area of child care. The work was time-limited, and the scope of it was to look at difficulties within

the staff team and the care and management of challenging behaviour. The monitoring officer was familiar with the centre and its difficulties, and thought at the time that it was reasonable to try and assist the staff group in dealing with them.

Inspectors consider that providing consultation and training to staff can be compatible with the role of monitoring officer. Indeed, the work the monitoring officer had done in the centre up to November 2003 assisted her in recognising that the centre could not provide safe care for the children at that point. The monitoring officer is commended for her decisive action in this matter. However, subsequent to the closure of the centre, she became involved in trying to resolve difficulties in the management of the centre. She recognised that this entailed her stepping outside her position as monitoring officer, and she sought approval from the ACEO for this change of role. However, at the time of inspection she had resumed her monitoring role, and when asked by inspectors whether the management arrangements in the centre could be made to work, she stated that, given her attempts to bring this about, she was not in a position to give a dispassionate response.

Inspectors consider that the monitoring officer had acted appropriately in recommending the temporary closure of the centre. However, she was subsequently placed in a position where she was asked to take on a role that was not compatible with that of monitoring officer.

Recommendations

5. The ACEO and line managers should act on monitoring reports that indicate shortcomings in the performance of a centre.

6. The ACEO should ensure that the monitoring officer is not required to take on functions incompatible with her role.

4.4 Children's rights

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

4.4.1 Access to information

Inspectors were given a draft copy of a document on children's access to information. It included a list of good practice guidelines for staff. The centre manager is commended for this work. These good practice guidelines should form the basis of a policy on children's access to information.

There was evidence that the children had access to their files, and this was particularly apparent as key workers assisted the children to look through their care files for relevant information in carrying out life story work. Staff also told inspectors that there was information available to the children from the Irish Association for Young People in Care (IAYPIC).

4.4.2 Consultation

On a day-to-day level the children were consulted about food, shopping, choosing clothes, and deciding on activities throughout the week. Inspectors also learnt that a number of children's meetings had taken place at the centre in the past. Inspectors urge that, as the numbers of children accommodated in the centre increase, these meetings should be re-introduced.

The children were not consulted about the decision to close the centre temporarily in November 2003. Two of the children were placed on an emergency basis with foster carers who were unknown to them. One of these carers had been identified as a future potential respite carer for one young person, but unfortunately there had been no previous consultation or contact, and the young person was placed there on an emergency basis. Consultation in care planning assists children understand options available to them and involves them in key decisions about their lives.

Recommendation

7. The external line manager should ensure that there are adequate arrangements in place for consulting with the children about the care they receive.

4.4.3 Complaints

There were clear written records of complaints which showed how the centre manager dealt with complaints in a positive and swift manner. There was also evidence of staff working through complaints with children. For example, one child had a disagreement with a staff member and records showed how the disagreement had been resolved to the child's satisfaction. On another occasion there was evidence to show that staff supported and listened to a child who complained about his care in a previous placement, and as a result he agreed to go for counselling. However, inspectors were concerned that staff did not appear to recognise that one child's frequent complaints indicated a general unhappiness with his placement at the centre. The external line manager had not been aware of his complaints, highlighting inadequacies in the external management of the centre.

Complaints procedures became unclear when the processing of complaints went outside the centre. For example, during the closure of the centre one child was unhappy about being placed on an emergency basis with foster carers he had never met before. On that occasion he left the foster carers' home and returned to the centre to find it closed. He then presented himself to the Gardai as homeless. The Gardai contacted the Crisis Intervention Service, (managed by another board on behalf of the three eastern boards), and the child was placed in emergency accommodation. The child made a complaint about having to move out of his home to the manager of the emergency centre in which he was placed. This information was passed onto the monitoring officer for that area, who in turn reported it to SSI. Inspectors found no written record of this complaint in the centre or in the child's care file, and the child's social worker told inspectors that she had not been notified of the compliant.

Recommendations

8. The principal social worker should ensure that all outstanding complaints are resolved

9. The ACEO should put in place a comprehensive system to ensure complaints made by children in the care of the board are dealt with promptly and children are told the outcome of their complaints. The board's monitoring officer should be notified of all complaints and undertake regular audits of the investigation process and outcome.

4.5 Planning for children and young people

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

4.5.1 Suitable placement and admissions

There were no policies and procedures on placements and admissions in place. However, the monitoring officer informed inspectors that work had begun on their development. Originally, the children admitted to the centre had come from another residential centre that had closed down. The last admission to the centre had been three and a half years before the inspection. At the time of the inspection inspectors were told that one referral for admission was being considered. Inspectors recommend that there should be no further admissions to the centre until the difficulties in relation to the management of it have been resolved.

The two children in the centre at the time of inspection had been placed there at age four and five years respectively. This is not compatible with good child care practice. The board had decided that, in future, only children aged twelve years and over would be considered for placement in a children's residential centre.

Recommendation

10. The general manager should ensure that there are no further admissions to the centre until the difficulties in the management of it are resolved.

4.5.2 Statutory care plans and care plan reviews

The SWAHB standard care planning and care plan review documentation was good. There were care plans in place for both of the children. The care plans and their reviews were completed as required under *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 23*. Inspectors found that there was good attendance at care plan meetings, and they mainly included the young person, parent(s), key worker, social worker, social work team leader and centre manager. The care plans set out objectives and tasks to be completed by individuals, the times scales to carry out the tasks, and their outcomes.

Statutory reviews were completed according to the regulations by the children's social workers. Reports were sought from schools, general practitioners and other professionals. There was evidence to show that, on the whole, the children's views were considered. The keyworkers played a significant role in preparing the children and in ascertaining their views prior to the review meetings. As with care plan meetings, review meetings on the whole were well attended.

Inspectors noted that the care plans stated that a foster placement was deemed the placement of choice for some of the children. One of the children had requested a placement in foster care for some time, and there was a letter from him on his file regarding his wish to be fostered, but a fostering placement was not found for him until the centre closed. Another young person found his own alternative accommodation with his friend's parents. A third young person had been placed in short term foster care when the centre closed temporarily.

Inspectors were told by social workers that they had made every effort to find foster placements but that none were available to them. In light of the placement developments following the temporary closure of the centre, inspectors urge the board to rigorously review the suitability of placements for all children in SWAHB residential centres. Undertaking a review of this type is of particular importance given that children of a young age with a stated preference for foster care have found themselves in residential care.

The placement plans were reviewed on a monthly basis by the key workers. The placement plan set out monthly goals. The placement plan reflected in the main the care plan objectives.

Recommendations

11. The principal social worker should call statutory care review meetings for the children in the centre to establish their optimal placement and pursue its outcome as a matter of priority.

12. The ACEO should undertake a review of the suitability of placement for all children in residential care, determine if there are children awaiting a foster care placement and, if necessary, develop a plan to meet this need.

4.5.3 Contact with families

Inspectors found evidence of regular contact between the children and their families. In one instance a worker had been employed by the board to facilitate contact between a parent and a young person. There were occasions when parents visiting the centre were facilitated to do so by taxi. Most of the contact between the children, their families and significant others such as foster carers was outside the centre either in health board facilities or at the family home. One of the children had contact with her sibling in the foster carers' home.

4.5.4 Social work role

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

There were two social work departments, CCAs 3 and 4, involved in the supervision of children at the centre at the time of inspection. Inspectors found that social workers had completed care plans and had undertaken statutory reviews. They visited the children on a regular basis and also arranged to see the children privately. They met regularly with keyworkers and discussed how the children were getting on and how plans were achieved.

The area of advocacy should be further addressed by the social workers. One social worker said that she did not like to question staff about the centre's care of the children. Some social workers remained unclear about the monitoring officer's function and how the centre was recommended for temporary closure.

The working relationship between the centre staff and social workers was generally good. However, some clarification of roles and responsibilities was required. As stated in section 4.2.6 above, some centre staff felt that they did not always get all the information they required from social workers. On the other hand, some social workers were concerned that centre staff wanted them to take responsibility for the management of the behaviour of children in the centre.

Recommendation

13. The principal social worker and centre manager should ensure that there is clarity of roles and that there are clear processes for communication between social workers and centre staff.

4.5.5 Emotional and specialist support

Inspectors found that the keywork system within the centre was good. Each young person had two keyworkers. Their role was important in giving emotional support to the children, in working directly with them about their life events, and in writing up placement plans. In particular, the training staff received in 'life story work' and its implementation in the centre had enhanced their keyworking with the children. Staff reported that this was especially important for the children. Some key workers maintained contact with children who had left the centre, and they are commended for doing so.

On the whole inspectors found that there was limited access to specialist support. One young person was attending counselling; another had recently been referred to a child guidance clinic and was waiting for an appointment. Inspectors also learnt that one young person had been assessed by a psychologist, who had recommended extra staff be employed to help look after her; however inspectors were told that this was unattainable because of staff shortages.

Inspectors are of the view that access to specialist advice and consultation could have helped staff work with some of the challenging behaviours shown by the children in their care. Children who have experienced attachment disruption and loss show their feelings in different ways, and staff need guidance to respond in individual, sensitive and appropriate ways that are helpful to the children. This is of particular value where children have challenging behaviour.

Inspectors had grave concerns regarding the emotional impact of the temporary closure of the centre on the four children, some of whom had lived there for eight years. Some of these children had already experienced their previous long term care placement closing on a permanent basis. Following the temporary closure of this centre, inspectors were told that one child was placed in another residential centre for one night and then with emergency foster carers, whom he had not met before. (section 4.4.3). In talking about this experience to staff, he described how upset he was when he tried to get into his home (the centre) to find no one there. Inspectors were told that key working staff were helping the children discuss their feelings around the temporary closure of the centre.

Recommendations

14. The ACEO should ensure that children's residential centres are managed and staffed in such a way that they provide continuity of care.

15. The principal social worker and centre manager should assist staff in working with the children in their care by accessing specialist advice and consultation for them.

4.5.6 Preparation for leaving care and aftercare support

The draft document for residential services (SWAHB) stated that preparation for leaving care "should be an integral part of the care process". The board is urged to implement after care policies and procedures in its residential centres.

Inspectors were told that some outreach support had been provided to young people who had left the centre. This is commended.

Recommendation

16. The ACEO should implement policy and procedures for preparation of leaving care and after care support services.

4.5.7 Discharges

Inspectors were told that where possible young people were discharged from the centre in a planned manner and discharges were discussed at care plan meetings and reviews. When there were unplanned or emergency discharges, a plan was put in place with all relevant parties to ensure that there was relevant information for new carers, and to review whether there should be continued contact by staff for a period.

Prior to the closure of the centre one young person had been admitted to hospital for observation. This young person decided not to return to the centre and left the hospital to return to her parent. During the inspection there was confusion amongst the staff team as to whether this young person's placement was being kept open or whether she had been formally discharged from the centre.

Inspectors were concerned to learn that as a result of the temporary closure of the centre, one young person experienced four placement admissions and discharges within a two week period. (See section 4.5.5).

The temporary closure of the centre on an emergency basis brought about the discharges of two young people at an earlier stage than anticipated. Where possible young people should be discharged from the centre in a planned manner and discharges should be discussed at care planning review meetings.

Recommendation

17. The centre manager and principal social worker should develop a policy on planned discharges from the centre.

4.5.8 Children's care records

The children's care records were good. The care files were systematically filed and there were ten sections on each file. The social history reports written by the social workers were comprehensive; they covered a number of areas such as family composition, reason for admission and details of medical history. One of the care files on a young person contained details about his siblings which should have been filed in a separate file. The daily diary/log book was comprehensive and there was a checklist sheet which guided staff on how to complete records appropriately. Social workers confirmed that the children saw their daily log books.

4.6 Care of young people

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

4.6.1 Individual care in group living

Inspectors observed positive interaction between the staff and the young people. Each day a plan was set out for each individual child. During school term, the children were helped with their homework and time was also spent by the key worker with them. Supper at 7.30pm followed television from 6.00pm. The youngest child went to bed around 8.30pm and the oldest went about 10.00pm.The children were involved in activities in the community such as GAA, athletics, gymnastics and they were encouraged to visit the local library. The children had their own bedrooms. They kept them tidy, and they also helped with general chores around the house on the weekends. They were involved in shopping for clothes of their choice and staff talked with them about personal hygiene and health care. The children also enjoyed activities away from the centre at weekends and throughout the holiday periods. Attempts were made to ensure that they were given the same access to activities and holidays as their peers who are not in care of the health board. The centre celebrated birthdays and special occasions and the children's family and friends were welcomed to the centre.

Social workers interviewed by inspectors said that they had, at times, questioned the suitability of the children's placements. One social worker was concerned about the centre's ability to manage a child's behaviour; another was concerned about the centre's ability to provide care, as she had heard from staff on the telephone that a young person was well and then a few hours later was contacted by staff to say the centre was closing down. The contrast in information made her consider if the placement was suitable for the young person.

While inspectors found many examples of good practices, the overall standard of care was not as good as it should have been because of difficulties highlighted elsewhere in this report. This was particularly apparent in relation to the temporary closure of the centre.

4.6.2 Provision of food and cooking facilities

The provision of food within the centre was good. Inspectors noted and were told by staff that the young people ate their meals separately from one another as they returned from

school at different times. One young person also had a specific meal plan. The centre manager should look at ways of encouraging the children to sit together with staff for their meals at least some of the time.

Recommendation

18. The centre manager should look at ways to encourage the young people to sit down for meals together on occasions.

4.6.3 Race, culture, religion, gender and disability

The draft policies and procedures manual for Dublin South City Residential Centres (SWAHB) highlighted the need for residential centres to contribute towards the development of a positive sense of self for the young person. The Child Care (Placement of Children in Residential Care) Regulations, state that children should be facilitated in the practice of their religion, taking into account the views expressed by their parents and the wishes of the young people according to their age. Inspectors learned that the youngest child practiced her religion.

There was an absence of male staff employed at the centre. Inspectors are aware of the difficulties in recruiting men to the area of social care. However, the centre catered for a mixed gender group. Inspectors consider it important that young people have access to good adult male roles models and the board is urged to take measures to attract and retain male care staff.

4.6.4 Managing behaviour

The draft policies and procedures manual for Dublin South City Residential Centres contained guidelines for the management of behaviour. It stated that consequences should be age appropriate; that consideration should be given to young people's developmental needs; and that the young people should understand the consequences and their relevance to challenging behaviour. The draft policy manual also outlined sanctions that should not be used by staff such as refusal of visits and contact with family members; withholding or use of medical treatment; physical searches; restriction of liberty; corporal punishment, and deprivation of food. Sanctions were recorded in a consequences book.

There was evidence that sanctions had been used excessively. Inspectors noted that from March 2003 to August 2003 there had been a total of 177 sanctions imposed on four young people. Some of the sanctions imposed were not appropriate; some sanctions did not consider the age of the child and at times there was double sanctioning. Inspectors noted a sanction where a pocket money fine was disproportionate to the offence where a young person was fined three euros out of her total pocket money of four euro fifty cent. Another young person was rude to staff but the sanction prohibiting television was not put in place until the next day. Inspectors advise the manager that consequences for children should take immediate effect and should not be prolonged.

Inspectors were told about a method of consequences previously used in the centre following aggressive behaviour, called full or half consequences. In practice this meant that the child or young person who had done something wrong spent hours not being allowed to integrate with the other young people or staff. This could last for an evening and at times it carried into the next day. Inspectors were told by staff that they had been unhappy with this form of sanctioning and this method was no longer used at the centre. From September 03

to February 04 there was a less punitive approach to managing behaviour and there had been a total of 16 sanctions imposed. Whilst two of the four young people had left the centre by November 2003, this was still a significant reduction.

Inspectors were concerned to learn the monitoring of sanctions was inadequate. The manager did not sign the sanctions book, and the principal social worker and supervising social workers did not read it. This was a serious omission as the level of sanctions imposed was an indication that all was not well in the centre and should have alerted external managers to difficulties at an earlier stage.

At the time of writing this report the approach to behaviour management was under review.

Recommendations

19. The centre manager should ensure that:

- **there are written policies and procedures in place for the management of behaviour,**
- **there is access to consultation about managing behaviour,**
- **staff receive training in this area.**

20. The centre manager should read and sign the sanctions book, and the external managers, the monitoring officer and social workers should read the sanctions book from time to time.

4.6.5 Restraint

Staff were trained in Therapeutic Crisis Intervention (TCI). The centre had a policy of not using restraint except in extreme circumstances. Records showed that one young person had been restrained three times in the same day. This ought to have been reviewed at the time but was not. In 2003 there had been 6 physical restraints in total and incidents of restraint were notified to the social worker, the monitoring officer and child's parents.

4.6.6 Absence without authority

The health board had a policy on unauthorised absences. This policy stated who should be notified and the time frame. Those notified included the centre manager, line manager, the young person's social worker, the general manager, the ACEO, parents, the Gardai, local hospitals and voluntary agencies in the area.

There had been three unauthorised absences over the past twelve months. The staff knew where the children were (in the locality or at a friend's house) and the children either returned by their own volition or were accompanied by staff. The children had left the centre without permission but there was no general concern about their welfare. Nonetheless, the full rigour of the notification policy was implemented with notices of absence going to all the above mentioned. The approach to the absence of a child or young person from a children's residential centre should be based on a risk assessment.

Unauthorised absences were recorded in the young person's daily log book, daily diary and in incident sheets

Recommendation

21. The ACEO should review the appropriateness of the current policy on unauthorised absence for community based children's centres

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

Inspectors found that a number of areas of concern impacted on the safe care of the young people. They included poor internal management, overburdened external management, lack of supervision within the staff team, poor strategies for dealing with challenging behaviour, and gaps in staff vetting.

Inspectors were told by staff that they were attentive to safe practice and they felt able to bring their colleagues' or the manager's attention to areas of concern. The monitoring officer also provided a safety net by regular visits and reports to the ACEO.

Recommendation

22. The ACEO should support safeguarding practices in the centre by putting in place effective management systems.

4.7.2 Child protection

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

Child protection procedures at the centre were guided by Children First: National Guidelines for the Protection and Welfare of Children. Centre policies stated that all child protection concerns must be reported to the centre manager, who should inform the social work department and, in writing, the child care manager. There was evidence of staff following procedures in some instances, for example one young person made allegations about his previous placement and this was notified to the child care manager. Inspectors were told, however, about a young person who was assaulted by another child, but the staff did not know if this had been notified under the child protection procedures.

There had been a half day briefing on Children First for staff. The board is urged to provide staff with adequate training in child protection. The child care manager should ensure that the centre receives feedback following notifications of concern. The child care manager should also be involved in developing child protection policies and procedures for residential centres.

Recommendations

23. The ACEO should ensure that adequate training in child protection is provided to centre staff.

24. The child care manager for the area should ensure that the centre receives feedback on child protection notifications.

25. The child care manager should oversee the development of child protection policies and procedures for the centre.

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.

Inspectors found evidence that, in general, the staff were supportive to the children in the area of education. The centre staff met with the young peoples teachers on a weekly basis. The key workers encouraged the young people to reach their educational goals by completing their homework each evening and monitoring their educational progress.

Inspectors were told by one young person that during the temporary closure of the centre, she had missed two weeks schooling because her foster placement was too far away from her school. This was a very serious consequence of the centre being closed. This young person had not been offered any extra tuition during this period.

Recommendation

26. The ACEO should ensure that where children have moved placement their educational needs are attended to as a priority.

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 standard on health was good. Staff gave appropriate guidance to the children on self care. The centre had good links with the local general practitioner, who continued to provide regular screening of the young peoples' health. He also gave staff advice about diet and eating habits, particularly in relation to one child.

At the time of the inspection medication was kept in an unlocked cabinet in the staff room. It contained cough medicine and ointments. Inspectors learnt subsequently that the centre manager arranged for the installation of a secure locked medicine cabinet in the centre.

4.10 Premises and safety

The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

4.10.1 Accommodation

The centre was based in a detached house in a suburban residential location in Dublin. The ground floor consisted of a hallway, a large lounge, a small play room and a substantial

kitchen with patio doors to the garden. The staff office was based in the converted garage attached to the house. Staff reported that the staff office was damp and cold in the winter and it was noted that this room was in need of redecoration. There were gardens to the front and the rear of the house. A wooden shed was placed in the back garden but it was in poor repair and contained broken furniture. There were six bedrooms upstairs. Two of these bedrooms were used by staff. The children's bedrooms were spacious and personalised. Inspectors were told that following the temporary closure of the centre, staff set about decorating parts of the house in an attempt to make it more homely for the children on their return. At the time of the inspection the house was in need of redecoration.

Recommendation

27. The general manager should ensure that the centre is redecorated.

4.10.2 Maintenance and repairs

The manager kept a maintenance book and recorded items that needed repairing. There was some delay in getting maintenance work done in a timely fashion. A recent example was that the manager was waiting a number of weeks to get the washing machine fixed. The centre staff have also found it difficult to get rubbish removed from the garden.

Recommendation

28. The general manager should ensure that repairs and maintenance to the centre are dealt with promptly.

4.10.3 Safety (including fire safety)

The centre did not have written confirmation from a certified engineer or a qualified architect that all the statutory requirements relating to fire safety and building control had been complied with. An up-to-date statement on fire safety, fire precautions and emergency procedures, drawn up in consultation with the fire safety authorities was not available. The monitoring officer reported this to the ACEO in March 2003.

Maintenance checks had been carried out to the fire alarm and emergency light system in October 2003. The last maintenance check on the fire alarm system was November 2003.

The staff and young people had not participated in fire drills in the past year. There were two members of staff elected as safety representatives but staff had not received training in fire prevention and evacuation since 2002. Inspectors learned that new training in this area was being organised for later in the year.

There was a policy of no smoking in the centre. Inspectors were told that staff were allowed to smoke in the back garden as long as it was out of sight of the young people.

The standard on safety was not met. The board is required to ensure the centre is physically safe as a matter of urgency.

Recommendations

29. The general manager is required to provide SSI with a copy of the written confirmation of a certified engineer or a qualified architect that all statutory requirements relating to fire safety are complied with.

30. The general manager is required to provide SSI with a copy of a Health and Safety Audit and to attend to its recommendations.

31. The general manager should provide staff with training in fire safety and first aid as a matter of urgency.

5. *Summary of recommendations*

1. **The ACEO for child care should ensure that there is a written statement of purpose and function for the centre.**

2. **The ACEO should ensure that there are adequate arrangements for the internal and external management of the centre.**

3. **The general manager should ensure that Garda checks and three references are acquired for all staff prior to taking up duty.**

4. **The centre manager should ensure that all staff, including the deputy manager, have regular formal supervision.**

5. **The ACEO and line manager should act on monitoring reports that indicate shortcomings in the performance of a centre.**

6. **The ACEO should ensure that the monitoring officer is not required to take on functions incompatible with her role.**

7. **The external line manager should ensure that there are adequate arrangements in place for consulting with the young people about the care they receive.**

8. **The principal social worker should ensure that all outstanding complaints are resolved.**

9. **The ACEO should put in place a comprehensive system to ensure complaints made by children in the care of the board are dealt with promptly and children are told the outcome of their complaints. The board's monitoring officer should be notified of all complaints and undertake regular audits of the investigation process and outcome.**

10. **The general manager should ensure that there are no further admissions to the centre until the difficulties in the management of it are resolved.**

11. **The principal social worker should call statutory care review meetings for the children in the centre to establish their optimal placement and peruse its outcome as a matter of priority.**

12. **The ACEO should undertake a review of the suitability of placement for all children in residential care, determine if there are children awaiting a foster care placement and, if necessary, develop a plan to meet this need.**

13. **The principal social worker and centre manager should ensure that there is clarity of roles and that there are clear processes for communication between social workers and centre staff.**

14. **The ACEO should ensure that children's residential centres are managed and staffed in such a way that they provide continuity of care.**

15. The principal social worker and centre manager should assist staff in working with the children in their care by accessing specialist advice and consultation for them.

16. The ACEO should implement policy and procedures for preparation of leaving care and after care support services.

17. The centre manager and principal social worker should develop a policy on planned discharges from the centre.

18. The centre manager should look at ways to encourage the young people to sit down for meals together on occasions.

19. The centre manager should ensure that:

- **there are written policies and procedures in place for the management of behaviour**
- **there is access to consultation about managing behaviour**
- **staff receive training in this area**

20. The centre manager should read and sign the sanctions book, and the external managers, the monitoring officer and social workers should read the sanctions book from time to time.

21. The ACEO should review the appropriateness of the current policy on unauthorised absence for community based children's centres

22. The ACEO should support safeguarding practices in the centre by putting in place effective management systems.

23. The ACEO should ensure that adequate training in child protection is provided to centre staff.

24. The child care manager for the area should ensure that the centre receives feedback on child protection notifications.

25. The child care manager should oversee the development of child protection policies and procedures for the centre.

26. The ACEO should ensure that where children have moved placement their educational needs are attended to as a priority.

27. The general manager should ensure that the centre is redecorated.

28. The general manager should ensure that repairs and maintenance to the centre are dealt with promptly.

29. The general manager is required to provide SSI with a copy of the written confirmation of a certified engineer or a qualified architect that all statutory requirements relating to fire safety are complied with.

30. The general manager is required to provide SSI with a copy of a Health and Safety Audit and to attend to its recommendations.

31. The general manager should provide staff with training in fire safety and first aid as a matter of urgency.